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RETHINKING POPULATION

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WOMEN'S HEALTH AND RIGHTS : RETHINKING POPULATION

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TECHNICAL REPORT SERIES

This Technical Report Series is part of the Hivos - India Regional Office's effort to participate actively in the debate and dialogue in India on issues of human development and emancipatory interests. This series consists of monographs, working papers and Hivos conference proceedings. It reflects policy concerns of Hivos regarding issues of human interest in India and other third world societies and addresses the problems faced by the marginalised in developing countries, such as in the areas of humane governance, environment, gender, the politics of development, technology choices and economic activities.

Series Editor: Shobha Raghuram

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Shobha Raghuram
Anika Rahman

* The Co-ordination Unit, Bangalore, a technical support initiative was set up to support grassroot women's organisations in their preparations for the Fourth UN World Conference on Women, Beijing 1995. After facilitating several pre- and post-Beijing meetings, disseminating information, and translating documents into regional languages it has closed.

CHAPTER 1

CHARTING THE REPRODUCTIVE RIGHTS AGENDA

Shobha Raghuram and Anika Rahman

A major challenge in development work is to bring issues of reproductive rights into mainstream debates of gender, population, environment and so forth. This issue, which takes a step in this direction, was engendered by a workshop organised in Bangalore on "Women's Health and Rights: Rethinking Population". It provided a forum for consultations meant to deepen our understanding of these issues and women's responses to their experiences in this field. The three-day workshop, jointly organised by Humanistic Institute for Co-operation with Developing Countries (Hivos), The Center for Reproductive Law and Policy, New York, and the Co-ordination Unit - Bangalore, focused on major reproduction-rights issues including the population theory, the "Population" policy and the ICPD, legal and policy frameworks in India, and the inadequacies of the Law. A rights - based framework was developed so that grassroot workers and policy makers could not only understand the connections between different types of harm suffered by women, but also make interventions in field settings for securing their rights. More than forty-six women, from the four southern states of Kerala, Tamil Nadu, Andhra Pradesh and Karnataka participated actively in the workshop.

They were from different initiatives which focus on one of the following areas:

1) women's health initiatives;
2) Government of India family welfare programmes;
3) Women in Development programmes;
4) Integrated Rural Development Programmes.

In the last few years many women's organisations, working broadly on economic - and social-justice issues, have felt the need to bring the issues of reproductive rights into mainstream discussions. To a large extent this has been prompted by increased government interventions in family planning, the aggressive marketing of reproductive technologies, and the negative after-effects endured by women, subjected to invasive techniques. Development projects of the '70s and '80s, very often gender-anonymous, have been called into question. Reproductive rights are a significant demand by women for control over their selves, their bodies, and their choices within the family. Women have struggled long to obtain recognition for their social, economic and political rights. Cutting across this spectrum of demands are the issues that constitute the reproductive rights terrain.

Today, women's resistance to the myriad ways in which patriarchal systems controlled, subordinated and directed their lives is evident in their demand for participation in gram sabhas, mahila mandals, and other grassroot political life worlds. And as women begin their journey of self discovery, their search for autonomy, they will be demonstrating the reconstruction of their positions in their communities, in their families, and in their personal relationships. The demand for equal histories needs to go with the availability of justice itself.

Debates at the recently concluded International Conference on Population and Development (ICPD) have brought the issues of reproductive rights and reproductive health to the forefront of discussions regarding population. However, these principles are yet to be understood fully. Although there is an increasing international commitment to implementing a reproductive-health paradigm, models for the integrated delivery of such key health services are yet to be designed. Nor have the scope and content of reproductive rights been completely articulated and understood in concrete terms. At the ICPD, governments agreed that "...reproductive rights...rest on...the right to attain the highest standard of sexual and reproductive health"[1]. The reproductive health and rights movement is involved in enhancing the understanding of the complex cross-disciplinary nature of such rights and in grounding reproductive rights upon the lives of women. Concrete applications of reproductive rights at the grassroot level will be particularly effective in bringing home their importance.

A. Reproductive Rights

Reproductive rights are at once simple and revolutionary. Stated simply, reproductive rights provide women with the freedom to control their bodies and obtain needed health services. Yet respect for these rights has profound consequences. All women could maximize their chances of enjoying good health, accessing quality reproductive health-care, entering only into consensual sexual relationships and deciding the number and spacing of their children. The promotion of women's reproductive rights is thus a key step in the creation of just societies that respect women's humanity and equality.

Women's reproductive rights can be neither addressed nor recognized without a basic understanding of the scope of such rights. The phrase "reproductive and sexual rights" can be regarded to mean "constellations of legal and ethical principles that relate to an individual woman's ability to control what happens to her body and her person by protecting and respecting her ability to make and effectuate decisions about her reproduction and sexuality"[2]. Hence, a critical aspect of women's reproductive rights is their right to control reproduction. Women must have the right to decide upon the number, spacing and timing of their children. But childbearing remains a complex social phenomenon and women's bodies are often pawns in the struggles among individuals, families, religions and states. Women must be empowered to reclaim their bodies and to regard childbearing as a personal choice. The right to control reproduction also implicates the following rights:

1) the right to liberty and security;
2) the right to decide whether and when to found a family;
3) the right to decide with whom to found this family;
4) the right to choose how and when to space births; and

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[1] Programme of Action of the United Nations International Conference on Population and Development, $7.3 (preliminary version, September 19, 1994).

[2] Lynn P.Freedman, Censorship and Manipulation of Reproductive Health Information: An Issue of Human Rights and Women's Health, in The Right to Know: Health, Human Rights and Reproductive Health Information (Article XIX, The International Centre Against Censorship, eds.)(forthcoming 1995).

5) the right of informed consent in all aspects of reproductive and sexual life.

Another central component of women's reproductive rights is the right to quality reproductive health-care. This right translates into a right of access to health services. Such services must be provided in a context that respects women's moral agency and that treats women as principal decision-makers in matters of reproduction and sexuality. Once again, there are numerous rights that are critical to realizing good health and quality care. These are:

1) the right to health;
2) the right of access to reproductive health-care, including family planning;
3) the right of informed consent;
4) the right to appropriate counselling; and
5) a whole host of quality of care issues -- such as method mix, counselling, etc --- which need to be regarded as rights issues.

One means by which to promote reproductive rights is by utilizing human rights principles. Human rights refers not just to general norms of justice and human dignity, but also to a system of rights guaranteed under the law. These principles provide a framework from which to expand reproductive rights and to establish minimum standards by which to determine the quality of reproductive health-care[3]. Increasingly, scholars and human rights activists have recognized that reproductive health-care together with the conditions that ensure meaningful, informed, and voluntary reproductive choice are within the scope of international human rights treaties and conventions that bind signatory governments to protect life, access to health-care and the benefits of scientific progress, privacy, security of the person, gender equality, and the right to marriage and family life[4]. Counselling, information and referral for reproductive health options are similarly protected[5]. A government's assumption of such obligations at the international level should be translated into action at the national level. Hence, a continuing challenge for the reproductive rights and health movement is to hold governments accountable to the principles pledged to at various fora. Women's health and their lives would also be vastly improved if governments could be held accountable to national laws and policies.

Locating these issues in societies divided by issues of class, caste, gender such as in India is a long and arduous task. Unequal literacy rates, a declining sex ratio for women, growing destitution for women within a growing informal sector have all added to the scales and

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[3] Rachael N.Pine, The Legal Approach. Women's Rights as Human Rights, XVI Harvard International Review 26, 27 (1994).

[4] See, E.G., Lynn P.Freedman and Stephen L.Isaacs, Human Rights and Reproductive Choice, 24 Studies in Fam. Plan 18 (1993); Rebecca J.Cook, International Protection of Women's Reproductive Choice, 24 N.Y.U.J. of Int'l L. & Pol. 401 (1992).

[5] See Case of Open Door and Dublin Well Woman v. Ireland, 64/1991/316/387-388, 246 Eur. Ct. H.R.(series A) (October 29, 1992) (interpreting and applying Article 10 on free speech of the European Convention for the Protection of Human Rights and Fundamental freedoms (1950)); see also Aryeh Neier, The Right to Free Expression Under International Law: Implications of the Mexico City Policy, 20 N.Y.U.J. of Int'l L. and Pol. 229, 234-37 (1987).

intensities of discrimination. The law, particularly in matters of family law, has disproportionately effected women. Women in most communities have fewer rights than men in most corresponding situations.

It is not surprising that the reproductive rights of Indian women, like those of the majority of the world's women, are constantly being violated. Despite the fact that 16% of the world's population live in India, the stake of our women in global policies (particularly in trade that affects women) is minimal. We are one of the few countries in the world where the sex ratio is declining - from 931 to 929 women per 1000 men in 1991. Female foeticide, dowry deaths, maternal mortality, in an overall setting of poverty and powerlessness are only a few of the overt forms of violence faced by women in India. In many ways the politics of health is really the politics of social life and development. There is a synergistic interaction between malnutrition and infection, between poverty and ill-health, and between ill-health and sexist politics. Personal testimonies of many of the women at the workshop reveal pictures of life for poor rural women - low incomes, low educational levels (in many northern states the literacy percentages for women is almost half of what it is for men), poor sanitary conditions, food intake much below normal requirements (women and girl children get even "less of the less"), repeated episodes of infectious diseases (skin, eye, respiratory and STD), too many children and too closely spaced (most women do not grow the normal full six centimetres during adolescence due to early marriage and early childbirth), low social status in society and high infant mortality rates. More children die in rural rather than urban areas. In 1978 between the 0-4 years age groups the percentage of deaths in this age group was 48.6% in rural areas and 36% in urban areas. More females (48.8%) than males (45.3%) die by the age of 5 years[6]. Hospitals reveal in both urban and rural areas that more male children are likely to be brought in for treatment in serious cases than girl children. Rural women are too young, anaemic, and undernourished and their babies consequently have low birth weight, and therefore are more susceptible to illnesses. Moral, physical and material deprivation is the brutal clinical history of most poor, ill, rural and urban women. In 1989 publication Prof. C.Gopalan wrote that every year 12 million girls are born in India and 25% of this number do not live to see their 15th birthday[7]. Indian Council of Medical Research (ICMR). records show that age specification death rates reveal that up to the age of 35 years more females than males die at every age level. The dire neglect of women in so many ways is directly related to the iron march of patriarchy. The agenda of political action must directly address reproductive rights so as to further humanise all development interventions.

Although it is difficult to measure the extent to which Indian women's reproductive rights are breached, certain practices and statistical trends can be used to indicate the contours of the problem. The maternal mortality rate in India -- 460 per 100,000 live births -- is one of the highest in the world[8]. It is estimated that every year 75,000 to 100,000 women die because of pregnancy and child-birth related reasons. The major causes of maternal mortality include

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[6] Ghosh, Shanthi, 'MCH Care and Social Barriers', P.4, Not published.

[7] See 'Women and Nutrition in India', Eds. C.Gopalan and S.Kaur, New Delhi, NF 1, 1989

[8] World Health Organization, Maternal Mortality: A global factbook 459, (1991).

anaemia (18%), haemorrhage (16%) and unsafe abortions (12%)[9]. The rate of maternal morbidity is projected to be 15 to 16 times higher than the number of maternal deaths[10]. The World Health Organization estimates that 1.6 million people in India are infected with the HIV/AIDS virus; one third of all those infected are women[11]. Reproductive tract infections and other sexually transmitted diseases are also a major health concern for Indian women. These figures testify not only to an inadequate health-care system, but also to women's loss of control over their bodies. This loss of control is further demonstrated by the high levels of domestic violence in Indian society. Dowry deaths have been on the rise. The violator of women's reproductive rights appears not just to be the state, but also other non-governmental actors such as doctors, religious institutions, health-care workers and family members.

The Indian women's movement has been actively engaged in advocating for women's rights on a range of issues, including domestic violence, bride burning and reproductive rights. Many women's organisations have been strongly opposed to the Indian state's drive to control fertility[12]. They regard the government's population policy as being "one of fertility control, pursued relentlessly, and at times coercively,..., bringing disrepute to the Family Planning Programme, compromising women's health, and accelerating the already declining sex ratio"[13]. Other women's groups have been less critical.

The government of India has been a powerful proponent of population control. In 1952, it was one of the first governments to launch a family planning program. India's population policy has been characterized by a drive to reduce fertility rates and to achieve demographic goals. The current Eighth Five Year Plan (the "Eighth Plan") reflects such concerns. The "containment of population growth through active people's co-operation and an effective scheme of incentives and disincentives" is identified as the sixth most important objective of government policy[14]. The government aims to reduce "the birth rate from 29.9 per thousand in 1990 to 26 per thousand by 1997[15]. A reduction in birth rates is to be accomplished by a "holistic approach to social development and population control, integrated programmes for raising female literacy, female employment, status of women, nutrition and reduction of infant and maternal mortality"[16]. Yet, the plan states:

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[9] Id.

[10] Chetna, Reproductive Health. Maternal Health. Abortion. AIDS and HIV. Reproductive Tract Infections. Contraception 10, (1994).

[11] William Branigan, Asia Faced With AIDS Apocalypse, Wash. Post, Dec. 2, 1993, at A38.

[12] See Perspective from the (Indian) Women's Movement On a National Population Policy (1993) (on file with The Center for Reproductive Law and Policy).

[13] Id.

[14] Government of India, Eighth Five Year Plan 1992-97, Vol.1, p.9 at Paragraph 1.4.2 (ii), (1992).

[15] Id. at Paragraph 12.5.1

[16] Id. at Paragraph 12.5.3(i).

The younger couples, who are reproductively most active will be the focus of attention, with necessarily a greater emphasis on spacing methods, although the terminal methods would continue to remain the important means of birth control. Medical Termination of Pregnancy will have to play an important role in the entire scheme of family planning in the Eighth Plan[17].

In addition, the Eighth Plan involved the restructuring of the current incentives that are utilized to encourage citizens to practice family planning. Community incentives in the form of priority considerations..., e.g., opening of schools, provision of drinking water facilities, linkages by road, etc., will be built up in the programme. The possibility of introducing certain disincentives to the non-adopters of family planning will also be explored and introduced with due regard to the freedom and fundamental rights of people[18].

India's population policies, in continuing to focus on fertility control, do not appear to be based upon a reproductive health model[19]. Although a concern with reducing fertility has led to the establishment of a national family planning program that has provided some women with access to contraceptives, the government cannot be regarded as being seriously committed to expanding the scope and quality of such programs. Moreover, policies have yet to be framed in terms of improving the health of its recipients, particularly poor Indian women. Because the Indian government does not adequately address the underlying socio-economic conditions within which its women citizens live, its policies possess the potential to aggravate the continued violations of Indian women's rights.

An exclusive focus on state culpability for inadequate reproductive health policies may serve to deflect attention from societal responsibility for pervasive violations of women's reproductive rights. Inadequate and misconceived population policies do violate women's rights in many respects. Yet, perhaps the most consistent violators of women's rights can be individuals and family members. A creative cross-disciplinary approach is required to tackle deep-rooted cultural practices which are articulated in ways that breach women's reproductive rights. The improvement of women's reproductive rights can begin by educating groups across an array of disciplines on the spectrum of concerns covered by reproductive rights. It is particularly important to reach out to grass-roots organizations and activists who are not part of the "already initiated." Increasing awareness of the concrete applications of such rights also enables each individual to be aware of the manner in which their actions could either enhance or violate the reproductive rights of others. Moreover, building alliances with grass-roots organizations can further ground understanding of reproductive rights upon the complex experiences of the majority of the world's women.

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[17] Id. at Paragraph 12.5.3(v).

[18] Id. at Paragraph 12.5.3 (xi).

[19] See Government of India, Ministry of Health and Family Welfare, Population Control. Challenges and Strategies, (1992).

This issue of the Technical Report Series brings together the perspectives of women engaged in building alternatives in various fields. Some of the papers clarify and highlight the legal framework and its finer implications; others anchor the status of women in legal theory and in reproductive rights. Yet other papers dwell on the social and political environment that informs women's struggles. They articulate the building of collective responses and women's definition of rights in their social and cultural setting. In the discussion notes the readers will come across brave attempts by many to forge definitions of reproductive health and to spell out the silences that have marked this area of work. The variety of papers by legal activists on the scope of the law, its strengths and its limitations, have all been set firmly in the Indian context; these should be of interest to women's organisations across the country. There is an important paper by a member of government who, until recently, was in the Ministry of Health and Family Welfare. This paper reflects the serious social negotiations going on between activists in the country and the Government on moving towards a target-free approach in some states.

The Discussion Notes are suggestive of strategies and provide recommendations for and pointers to the central areas of concern. Here, between the lines, we see the to and fro movement between two seemingly unbridgeable arenas of contestation. One is the legal system, public and open to all in principle, but in reality inaccessible for the members of the public; the other is the very private, closed life of deeply personal family relationships, where social and cultural values determine our bonds and the moral matrix of the lives of people.

It is in the realm of the private that denials and violence occur with sureness; and it is here that public-interest interventions have the most minimal chances of preventive action. In both these arenas the existing power relations dominate and women fall in the pale of the subordinated. When women carry the lessons of one arena forward quietly into the other, or choose not to do so, it is then that public-interest initiatives begin to be heard. It is then that alternative histories are created and written about. We are all quite sensitive to the home truth of how difficult it is for most of us existentially to realise our rights, even though we know that the rights discourse is central to our dignity. This collection of papers and discussion notes will, we hope, give all of us certain instruments which we may keep with us and use effectively to strengthen the position of women as they negotiate the domain of reproductive rights.

Part I

SETTING THE SOCIO-POLITICAL CONTEXT

CHAPTER 2

POPULATION POLICIES AND WOMEN'S HEALTH - THE SHIFTING BOUNDARIES *

Gita Sen

An Ideological transformation

Few areas in the development thinking of the last five decades have undergone the dramatic transformation that the population field has in the last four years. Although the antecedents of this change go back to early left criticism of Malthusian population control ideas, and to related critiques by women's health and development activists and advocates, the recent global change in mindsets and ideologies has been sharp and compressed in a very short time span. This paper examines the implications, both the potential and the limitations, of such a global level change for population and health debates and policies in the country.

First, a brief description of the nature of the changes that have occurred in population thinking prior to, during, and after the International Conference on Population and Development (ICPD) held in Cairo in September 1994.[1] Right from the early beginnings of family planning programmes in the 1950's, the main rationale and objective of population policy worldwide has been demographic control. The thrust and scope of family planning programmes have, in many settings, been vitiated by this population control ideology. The principal victims of this approach have been women's health and women's rights. Acts of commission such as the coercive use of sterilisation targets, incentives and disincentives, and the introduction of contraceptive technologies without adequate safeguards, and of omission such as ignoring the wide prevalence of reproductive tract infections and sexually transmitted diseases, the high incidence of cervical cancer, and the risks of unsafe abortions, have been all too prevalent in many countries including our own.

The Programme of Action (POA) of the ICPD represented the culmination of a groundswell of criticism against the above. While Marxist critiques of the Malthusian approach to population growth date back to Marx's own writings on Malthus, recent and innovative approaches in research, advocacy, and participatory reproductive health programmes have come from a variety of women's organisations. Their approach has been grounded in affirmation of women's health needs and concerns in the areas of reproduction and sexuality, and recognition of not only class and caste forces but of power relations based on gender. The result of their efforts, as reflected in the ICPD POA, is a shift in policy focus away from population control rationales and objectives in favour of women's reproductive and sexual health and rights within a broad primary health care context.

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* Forthcoming in SEMINAR.

[1] For more detailed analysis of the contents and politics of the Cairo document, see G.Sen "The World Programme of Action: a New Paradigm for Population Policy" in Environment 37:1, January - February 1995.

This transformation of the global debate is important, especially for a field such as population which has always been heavily influenced (in terms of both ideas and funds) by bilateral and multilateral development assistance. While some donors have long questioned the human rights implications of a population control approach in the subcontinent, it is only after ICPD that agencies such as the World Bank and the UN Population Fund (UNFPA) have begun to seriously consider a reproductive health and women's rights approach. Translating these ideas into programmes is a halting and difficult process requiring continuous and ongoing engagement by the protagonists of the new approach. Yet change in the attitudes and approaches of agencies in only a necessary, not a sufficient condition for change in policies and programmes. Global politics, even in this era of globalisation, is only one element affecting realities on the ground in the country.

Global politics versus ground realities

Not by reproductive health alone

Illness and death from reproduction related causes are particularly significant for women and have been insufficiently recognized as such until very recently. For instance, one of the first and best known empirical studies of reproductive tract infections was published as late as 1989.[2] Estimates of the percentage of Disability Adjusted Life Years (DALYs) lost by Indian women due to reproduction related causes (STD's, HIV, maternity, cervical cancer) were as high as 10 percent in 1990.[3] This is comparable to the losses due to diarrhoeal diseases (10%) and to respiratory illnesses (11%), and does not include the losses in the perinatal stages or losses due to protein/energy malnutrition, anemia, or unsafe abortions. If these were included, the figure would clearly be much higher. One major positive fallout of ICPD is that policy makers, health activists and researchers have begun to take reproductive health problems more seriously than before.

But a concern for women's health must look beyond the sphere of reproductive and sexual health per se. This is for two reasons. First, women and girls are at least as susceptible as men and boys to morbidity and mortality from a range of non-reproductive causes. For instance, there were no significant female - male differences in the estimated deaths in 1990 due to infectious and parasitic diseases, and respiratory infections, which together account for about a third of deaths from all causes.[4]

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[2] R.A. Bang et al, "High prevalence of gynecological diseases in rural Indian women", Lancet, 1 (8629), pp 85-88.

[3] DALYs are a composite measure combining the loss due to death, illness and disability. See C.J.L. Murray, A.D.Lopez and D.T. Jamison, "The global burden of disease in 1990: summary results, sensitivity analysis and future directions "in Global Comparative Assessments in the Health Sector (eds) C.J.L.Murray and A.D.Lopez, WHO, Geneva, 1994.

[4] See C.J.L. Murray and A.D. Lopez, "Global and regional cause-of-death patterns in 1990", in Global Comparative Assessment in the Health Sector (eds) C.J.L. Murray and A.D. Lopez, WHO. Geneva, 1994.

Second, a policy focus on reproductive health isolated from broader public and primary health care may be of doubtful efficacy because of the interactions between reproductive and other health problems. For instance, treatment of anaemia (a major reproductive health concern) by iron - folic acid supplementation has limited effectiveness in the presence of untreated hookworm and malarial infections. Similarly, management of a number of reproductive tract infections and sexually transmitted diseases is difficult in the absence of clean water and adequate sanitation. There is growing evidence of problems of uterine prolapse in women who have had as few as two or three children, resulting from the fact that their poverty and the lack of easy physical access to firewood, fodder and water means that they are forced to return to bearing heavy loads soon after child birth. Good reproductive and sexual health care is therefore predicated on adequate primary and public health facilities, including easy access to water and sanitation.

This synergy between reproductive and sexual health on the one hand and primary and public health on the other is rendered more critical by the country's deteriorating health infrastructure and the resurgence of diseases such as malaria in more virulent forms. A major dilemma therefore is how to address women's reproductive health needs when the primary health care infrastructure is in the appalling state that it is, and when budgetary finances for health have been cut back in the post 1991 fiscal environment.

The quality of family planning services

It may appear on the surface that this paucity of public funds has not really affected the family planning programme. Because of the historical dominance of neo - Malthusian approaches in population programmes, these have never faced a shortage of funds in the country. Indeed, protagonists of primary health have often pointed to the disproportionate resources traditionally available to the family planning programme. Despite this, the quality of services leave a great deal to be desired when viewed from the perspective of the women and men that the programme is intended to serve. A major reason for this is the programme's ambivalence between an ethos of service to its clients versus an ethos of control, with the latter usually winning out. The ethos of control has been fostered through incentive structures for service providers, management information and monitoring systems that reward those who meet contraceptive targets, regardless of the quality of the service provided. The actual reproductive or health needs of people have received short shrift as all levels of programme personnel, from the auxiliary nurse - midwife on upwards, have responded to the system of targets, incentives and disincentives. Clearly, availability of funds has not guaranteed service quality in the family planning programme. Indeed, it may have worked to further bias health delivery towards family planning work (for which there have been both targets and incentives) and away from other equally important health services. Because the ethos of control has become so ingrained over the years among personnel at all levels, improvement in the quality of services requires serious changes in incentive structures and management information systems, and significant commitment from the very top of the hierarchy.

Reproductive technology

Another major aspect of the ground level reality affecting reproductive health in the country is the problem of reproductive, particularly contraceptive, technology. Many women (and I include myself) tend to be nervous about introducing agents likely to alter hormonal balances

and systemic functions into their bodies on a long-term basis. As a result, the issue of technology has been one of the most difficult in the entire complex of population policy issues for two reasons. First, it has generated a great deal of disagreement and even open conflict. Women's groups have been concerned about the potential for abuse of long - acting, provider - controlled contraceptive technologies within a family planning programme that has been vertically driven by an excessive emphasis on meeting method - specific targets. Lack of transparency and general openness about test results and methods by those in authority has aggravated the problem.

The second reason for the difficulties in the public debate about contraceptive technology is lack of adequate technical information among both policy/programme implementers and among health activists. Information about the stage of development of particular technologies is not only hard to come by but also difficult to interpret, and this also affects the quality of the public debate.

The "inherent" characteristics of new contraceptives are usually judged by three criteria : safety, efficacy, and acceptability. The concern for safety is interpreted by scientists as requiring that the risk of mortality from unintended effects, eg., thromboembolisms or cardiac arrest, be minimised and within generally acceptable levels. Efficacy implies the method's contraceptive effectiveness, while acceptability refers to users' response to a particular method. Unfortunately, testing for acceptability is often suspect because it is conducted in family planning clinics which may have a vested interest in the outcome, and because acceptability is often inferred from method continuation rates rather than through detailed questioning or examination of the users.

While there can be little doubt that technology developers have delivered more and more effective methods of birth control, and have paid considerable attention to addressing immediate life - threatening risks such as embolisms or diabetic crises, they have paid much less attention to side - effects which do not threaten life, but which may seriously impair its quality. The most serious of these is abnormal bleeding which is a common side - effect of many contraceptive steroids. Indeed, excessive bleeding can be potentially quite risky in mal - or under-nourished women with a history of iron deficiency anaemia, which includes the majority of Indian women. Reduced or irregular bleeding or the absence of regular menstrual periods can be difficult to cope with in social contexts where there is no other easy way of testing for pregnancy, or where cultural practices are closely linked to regular menstrual cycles.

Feminists are also concerned about unknown long - term risks, particularly of cancer. Fundamental to women's concerns is a disquiet over introducing hormonal steroids on a continuing and long - term basis into their bodies. It is true that hormonal drugs are sometimes taken for long periods of time to counter illness, but women tend to object to thinking of their own bodies as "diseased" by definition, and feel that the largely male community of contraceptive researchers are only too willing to do so!

So far as contraceptive testing is concerned, three issues appear to be important. The first is the question of informed consent by the subjects of tests. Breaches of norms and guidelines appear to turn up with uncomfortable regularity in the country, especially among poorer and/ or politically weaker groups. The most recent example of this is the testing of quinacrine as a method of non - surgical sterilisation by a number of private physicians in Calcutta and

Bangalore (and possibly other sites) which appears to be completely bypassing the government's regulatory structures.[5] Private testing of quinacrine is going on in the country in blatant disregard of the WHO's insistence on the need for more toxicology studies before further clinical trials on human beings. Clearly, the governmental bodies responsible for ensuring that citizens of the country are not treated like guinea pigs are failing in their responsibility. Unfortunately, those in charge of regulating testing in the country are often less than transparent in their actions, and less willing to part with information than is desirable in the interest of public accountability. This has provoked considerable challenge to their credibility.

The second issue where testing is concerned is the point made by Hardon that clinical trials exclude women with characteristics such as anemia, under - nutrition, or who are breast - feeding.[6] These characteristics are excluded so that test results will not be confounded by their presence. The problem is that the test sample may not then be representative of populations that are predominantly anemic or undernourished. The third issue which has been pointed out by Snow is that there appears to be considerable variability among women in their responses to some of the newer steroids; the potential implications of such variability for test results has been poorly researched to date.[7]

Perhaps the most significant weakness arises at the stage of distribution and use of a method. In a context of widespread poverty, where the state of health, sanitation and other public services is poor, and where large numbers of women (indeed the overwhelming majority) suffer not only from anemia and malnutrition, but also from hypertension, what ought to be the criteria guiding the distribution of different methods? While contraindications for specific methods are known, there is considerable evidence of abuse since women are rarely tested before or followed - up adequately. If the argument is that such tests and follow-up are too expensive, then it clinches the arguments of many feminist groups who call for a blanket ban on all the new hormonal technologies. Those who favour a more discriminating approach to the different technological methods must work towards strengthening the distribution criteria for different methods, as well as better testing and follow-up.

What are the implications of all this for policy?

- First, it is high time that the family welfare programme increased its support for barrier methods (especially given the looming threat of HIV).

- Second, testing authorities (especially ICMR, the Drug Controller's office) should become more transparent, and concerned about being accountable to the public.

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[5] For a discussion of the risks and issues surrounding quinacrine, see M.Bere, "The Quinacrine controversy one year on", Reproductive Health Matters, No. 4, November 1994.

[6] A. Hardon, "The needs of women versus the interests of family planning personnel, policy - makers and researchers: conflicting views on safety and acceptibility of contraceptives", Social Science and Medicine, 1992, 35:6, 753 - 766.

[7] R. Snow, "Each to her own: investigating women's response to contraception", in G.Sen and R.Snow (eds), Power and Decision: the Social Control of Reproduction. Cambridge: Harvard Centre for Population and Development Studies, 1994.

- Third, there should be renewed emphasis on male methods, including condoms and sterilisation.

- Fourth, the government should implement its long stated goal of shifting towards superior technologies for safe abortion, viz., menstrual regulation rather than D&Cs.

- Stronger and more regular interactions between MOHFW, the research community and health activists should be supported in the interests of improving the climate of debate, increasing accountability, and enhancing the credibility of public institutions.

Difficult though it may be to effect such changes in policy and programme approaches, these appear easy when compared to the glacial speed of change in the power relations of gender in society. When crosscut as they are by forces of caste and class, gender relations function as major barriers to women's rights to health care, to control over their fertility, to bodily integrity and freedom from violence, and to autonomy over their sexuality. It is now well - recognised that gender based oppression, exploitation, and discrimination bedevil women's lives from early childhood until widowhood. Overwork, undernutrition, poor access to health care, and violence are norm for most Indian women. This is the overriding reality of women's lives.

What can be done?

Against these ground realities of gender, caste and class - based oppression, poor quality of health and family planning services, and low priority of public and primary health, what can the ideological shift away from population control towards women's health hope to accomplish? It is depressingly clear that the Alma Ata goal of "health for all by the year 2000" will not be met in the country. Nor is there much sign that health itself is much of a governmental priority at the present time. Yet what ICPD has managed to do is to infuse a new energy and interest in women's health even in this daunting climate.

New areas of health inquiry, new emphases on the specificities of women's health needs, and a thrust against traditional top - down methods of bureaucratic functioning have been energised by women's health activists and advocates. These hold some promise for potential changes. But while there is a growing consensus about what kinds of expanded services are required to meet women's reproductive health needs, there is less awareness of two related and equally critical areas - (i) how to use the reproductive health thrust to help improve and support primary health care more generally, and (ii) how to build new methods of accountability into service provision through the empowerment of women. These are, in my opinion, priority areas of concern. Exploring the potential of Panchayati Raj institutions in this regard is still in its infancy. Much more informed public debate about how such institutions can handle crucial aspects of girls' and women's health is clearly essential.

The only way to transform a heavily top - down programme such as Family Welfare, and to energise moribund primary health structures is to give planning, funding and monitoring powers to the community of users. To build accountability into the system, local communities and women in particular must be empowered to assess their health needs, define their priorities, and decide how resources should be allocated. However, since communities are also fraught

with caste and gender biases, the participation of lower caste groups and women must be built into the structures. Although this may work unevenly as we are seeing with the new panchayati raj institutions, there is no other practical way in which both accountability and participation can be built in.

Discussion Notes

The discussions revolved around the transformation of population policies in this country so that they were more responsive to the needs and concerns of the normal ordinary women of India.

Some of the women present at the ICPD at Cairo experienced mixed perceptions about the Cairo conference. A large majority believes that something quite remarkable happened there. For the first time, the countries of the world, came up with a document and an agreement on the Population Policy which had no demographic or population growth reduction targets or goals. Instead, the goals of the ICPD POA are set in terms of reducing maternal and infant mortality, raising the literacy levels of girls and improving women's reproductive health by looking at women's rights and empowerment as a methodology. Population policies, until the ICPD, have only been concerned with reducing the growth of the population both at the national and at the international level. ICPD, for the first time changed the old perspectives.

All the long term efforts of the women's organisations seem to be bearing fruits now with the recognition of the movement for the reproductive rights and health for the women. This, in turn, is linked to the access of the women to clean water and sanitation. The three forces that women directly face are, (i) economic system, (ii) a patriarchal government and state, and (iii) the problem of the age - old traditional hierarchies and structures of gender and patriarchy.

In the ICPD context, there are two important issues, 1) the law and 2) women's empowerment.

As very few existing laws are implemented in a way that is meaningful to women, a prioritisation is needed from the lawyers and social activists. Of particular concern is the Prenatal Diagnosis business. The latest techniques have made it possible to test the foetus through the maternal blood. In such cases, as there are few chances of punitive action, it becomes a social issue. The doctor who reveals the sex of the foetus should come under criminal sanction though it is extremely difficult to be implemented.

A large number of NGOs have been engaged in a continuous dialogue with the government for improving the quality and character of health services, in particular, the reproductive health services provided to women. Our entire system for the complete range of services is like a 'dinosaur' that is very difficult to move and change.

People engaged in this process of trying to improve family welfare services and improve the quality and scope of services for reproductive health, have formed a network called **"HEALTH WATCH".** The network has a series of newsletters. Anyone can become a part of the network and the mailing list by writing their name, address, telephone number and fax number. The newsletters will focus on problems of services and service implementation.

The basic objectives of **'HEALTHWATCH'** are:

1. To translate the ICPD programme of action for the national context by defining priorities for public policies and action and the mechanisms for their implementation.

2. To engage in a process of constructive, but critical dialogue with the government at multilevels and to lobby for a shift in the government's welfare programmes from provider driven to people based programmes.

3. To explore mechanisms to link reproductive health services, to strengthen public and primary health care and related aspects of development, especially education and women's economic, political and social empowerment and, in particular, to advocate restructuring government programmes, based on NGO experiences in this area.

4. To provide a forum for effective networking among like-minded NGOs to make progress on the above objectives.

5. To provide a forum for continuous exchange of information and sharing on ideas and experiences among NGOs themselves.

The newsletter of the network will have a regular page or a half-page, where people can contribute their experiences, questions and issues so that it becomes a vehicle for the exchange of experiences and information.

The main priorities in the service area are: (i) reduction in maternal mortality, (ii) the quality of family planning services, and (iii) the problem of reproductive tract infections and sexually transmitted diseases. The link on the other side is to HIV and AIDS. Motivation of men and young people to become part of the awareness programmes is an aspect that is neglected in government and even in NGO programmes.

The next issue in terms of services is the abortion issue. Marie Stopes, **Parivarseva**, are doing their bit on this front. As abortions are performed mostly on married women who already have two or three children, it is a problem that has to do with something that is very much in the core of what the majority of women face in their lives. A lot of these abortions can be avoided if proper contraceptive and birth control services are provided.

The other services that women need are the problems of reproductive cancers, cervical and breast cancers.

Tamil Nadu has been able to bring birthrates down, but in terms of women's health, people's health more broadly, a great deal needs to be done. This is true for Karnataka, Andhra and Kerala as well.

There are other issues apart from the priorities in terms of improving services and the first of those is the question of accountability through the Panchayati Raj institutions, but they have their own limitations.

Another way of making the system more accountable in terms of the quality of services that is provided is to hand over the responsibility to NGOs. One of the serious problems is that the successes of NGOs simply do not translate into the government programme.

The whole problem is of strengthening the primary health care system itself. There cannot be any improvement in reproductive health care services without a strong primary health care system. In a system that is really short of drugs, staffing, equipment and motivated personnel at the present time, it is very difficult to concentrate on the special gender focus and services that are needed.

CHAPTER 3

INTERNATIONAL PERSPECTIVES ON POPULATION POLICY AND REPRODUCTIVE RIGHTS

Anika Rahman *

The most important question that is raised on women's rights is, why should women be concerned about population and reproductive rights issue? What is the importance of these subjects to women? Reproductive rights deal with rights that enable individuals to exercise control over their body. Although the term "population" is about all people, because of the state of contraceptive technology and of societal roles, population policies have generally dealt primarily with women. Population policies, such as the traditional ones of nations such as India, that seek only to change women's fertility choices by providing a narrow range of services can be regarded as yet another attempt by governments to maintain societal restrictions over women's bodies. In several instances, population policies seek to affect the reproductive decisions of women, such as the number of children a woman wants and the type of contraception she uses. No matter what the government's position is on whether women should bear fewer or more children, it is clear that government policies that try to influence these decisions deal with some of the most private and intimate aspects of people's lives. When governments seek to deal with such important matters by not ensuring informed consent and by providing women with inadequate and inaccessible reproductive health services, they are infringing women's reproductive rights.

Political considerations aside, there is an enormous practical reason that dictates commitment to reproductive rights and 'population'. The world's "population" budget far exceeds almost everything so exclusively devoted to women. For example, take the commitments made at the International Conference on Population and Development in Cairo. The Cairo document states that over the next fifteen years, in Southern nations, approximately US $ 21.7 billion (or Rs.62 lakh crores) for reproductive health and US $ 13.8 billion (or Rs.43 lakh crores) for family planning will be available. In this discussion, the terms "South" and "North" are used interchangeably with "Third World" and "First World," respectively. The former refers to countries that are low to middle income and the latter to industrialized nations. There is thus a large pool of financial resources that can be used to promote women's rights and health.

Why is population important to so many groups and to governments? Which groups are interested in population issues? In this brief discussion, I will be writing in broad general terms of three perspectives on population and it is important to note that not all governments and organizations fit into these simple categories.

The most common view of "population" is what is known as the population control view that is followed by a number of Southern and Northern governments. The mainstream population control perspective, articulated by many governments, including the government of India, is based on the belief that population is growing at a much faster rate than society's production and resources. To balance the production of resources with the increasing number of people, the population growth rate must be reduced or, at least stabilized. The policies of many

governments - both in industrialized countries and in the Third World - and international NGOs are based on the need to reduce population growth. Such views are regarded as being especially true in the South where average income is low and fertility rates are increasing.

Critics of the population control view have charged that the perspectives are simplistic and racially biased. There has been, at least from certain progressive quarters in both the North and the South, a rejection of a simple look at just the number of people. We need to look at how society distributes its resources, how the government is established and what policies it pursues. In other words, we need to look at the distributional impact of policies. Does a government have a genuine commitment to its poor people? Is the political system democratic?

Charges of racial bias in the mainstream population control view are based on the fact that the population most often sought to be controlled are people who live in Third World countries. For example, Japan and Holland are almost as densely populated as Bangladesh. Yet, we do not hear about Japan's or Holland's "population" problem. Moreover, many Northern governments have stated that population control is an important means of reducing the number of immigrants they receive from the Third world.

The other constituency involved in the production debate is the international environmental community, which, as many of you know, is primarily First World dominated. Although I am by no means an environmental scientist, I regard this perspective as focusing on concern for the "carrying capacity" of the earth and the number of living things that the earth can sustain. Environmentalists often claim that the natural resources of the planet are finite and that the rapid growth in the number of people in the world cannot continue to be supported by the planet. In addition, many environmentalists claim that various types of animals and plants are "endangered" by the increase in the number of the people on the planet.

The progressive elements of the environmental movement take a somewhat different approach to "population" and emphasize consumption issues. As I see it, they claim that merely looking at the number of people in the world is inadequate. The impact of population on environment is tied to consumption per person. Low-income individuals and communities are not large consumers; rich individuals and nations, on the other hand, use a lot of the earth's resources. It is estimated that one American consumes as much as what 35 - 40 people do in Southern nations. So, for example, if one compares the consumption patterns of all the people of U.S. (250 million) with that of India (approximately one billion), it is clear that the environmental impact of people in the U.S. is eight to ten times greater than that of Indians. One logical conclusion of such facts would be to reduce population growth rates and/or consumption patterns in the U.S. Although environmentalists are attempting to change consumption patterns, there has never been an attempt to control population growth rates amongst the Anglo - Saxon community in the U.S.

Given the importance of "population" to women and the many perspectives on the issue, the next important question relates to the views of the international women's movement. In my opinion, the single most important contribution of the movement has been its deconstruction of the phrase "population". When we think of "population", it is about people. Second, the women's movement has successfully pointed out that current "population" policies focus on women. Third, the international women's movement has rejected a population control perspective which is regarded as one that aims solely to reduce women's fertility by providing a limited

range of contraceptives. Lastly, the women's movement has demanded that women's reproductive rights be regarded as human rights. Besides these basic principles, the women's movement has spoken with many different voices on "population". I regard the women's movement as having three major viewpoints on "population".

The first perspective is what I would describe as the "radical" one in which feminist groups reject all population policies and call for their elimination. They regard such policies as being tainted by their Western origin and by their focus on the fertility of the Third World and low-income women. Such groups advocate a holistic women's health policy in which all elements of women's health is included. There are no clear North-South divisions amongst this group of feminists, though I note that primary proponents of this perspective tend to be women from nations (Bangladesh, India, Brazil and others) where population policies have been implemented coercively.

A second category of feminist views is what I would describe as the "progressive" voice that calls for a "feminist" population policy. This group has advocated a broader women's reproductive health approach that is based upon a concern for women's health, empowerment and human rights. Hence, the progressive international women's movement has sought to move beyond a narrow family planning model to one that looks at other women's reproductive health issues such as abortion, infertility, STDs, safe motherhood, reproductive tract infections and issues of sexuality. Again, there are no clear North - South divisions in this group. But it must be acknowledged that this "progressive" group tends to have a disproportionate number of Northern women leaders. This "progressive" viewpoint is the dominant voice of the international women's movement.

The final category of women's voices is what I regard as the "traditionalist" ones. The main focus of this minority view is to continue to provide family planning services in the context of population policies; such women argue that women continue to need any and all types of contraceptives and that current policies that provide such services are beneficial. I do not see any particular North-South differences in this group. Given so many different views on "population", the question arises: What is the current dominant international perspective? In my view, the recent discussions at Cairo conference endorsed the need for a reproductive health approach that is to be based on women's empowerment and human rights. The Cairo conference supports these principles within a framework that views global population growth as being high. As you may know, Cairo represented a breakthrough for women and women succeeded in placing themselves on the agenda. It was the very first United Nations conference that endorses "reproductive rights" and that places women's empowerment at the centre of "population" and development. The Cairo conference reinforced, to a large extent, the views of the "progressive" wing of the women's movement.

In terms of prior population conferences, Cairo was unprecedented. Women spoke out and women's NGOs were present in numbers large enough to be able to lobby actively for their perspective. In effect, we saw a global women's movement in action. This movement changed the terms of the "population" discourse on women. Governments were made to realize that they must look at women's lives holistically. Women cannot make free decisions regarding child - bearing without improvement in their financial status, family life and other rights. For the first time the United Nations and governments began to regard women's reproductive rights as human rights

Before I end, let me try to raise a few questions regarding the current international perspective on "population". We must ask ourselves whether it endorses a utilitarian view of women. Governments were not persuaded to pay attention to women because we make up half of all countries of the world. Rather, they were convinced of the need for women's rights because paying attention to this would result, ultimately, in an improvement in changing words and rhetoric. The challenge for us today is to begin to think about changing lives.

In conclusion, the issue of "population" remains a contested one. The fact that there are so many views on it should at least point to its importance and to the central role that the women's movement has played in challenging conventional views. Clearly, the women's movement has influenced the global debate. The Cairo conference enabled the women's movement to break the myth that reproductive rights are just about women's access to health care. The women's movement was successful in communicating that reproductive rights are far more fundamental. Reproductive rights are about the real and very intimate issues that all of us face - our sexuality, who and when we marry, how many children we choose to have and how we protect our health. The challenge is for all of us to ensure that all women are able to exercise these rights.

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Discussion Notes:

The meanings of terms like 'population', 'population control' and 'stabilisation' were made clear. A few participants found definite directions in which to proceed regarding women's issues. It was decided that clarifications should be sought about directions and discussions regarding women's health and contraceptives. Also, it is very critical for the women's movement to take positions on these issues and to understand the different perspectives as players. Persons capable of pushing things ahead - such as those described as "radicals" and "progressives" - are needed as strategists. People willing to work with the available resources without pushing for more are also needed.

The women's movement has succeeded in bringing about progressive changes in reproductive health. Although current reproductive health and population policies cannot be changed overnight, the challenge is to improve the lives of women on both a short-term and long term basis by ensuring that population policies are not used as a means by which to limit the reproductive freedom of women, particularly low - income women. One solution that would enhance women's status has been offered by the Cairo conference. The Cairo document - without eradicating population policies - speaks of a reproductive health approach with a broader empowerment and rights context that is linked to sustainable development and population stabilization. While such views may regard women in utilitarian terms, it is important to assess the validity of the objective of policy. Laws and policies that seek to improve women's lives are morally more acceptable than ones that just seek to use women to achieve economic ends.

CHAPTER 4

EMPOWERMENT AND WOMEN'S AUTONOMY

Srilatha Batliwala

I will focus on the implications of the concept of empowerment for reproductive rights and autonomy and present the background of this particular conceptual framework. It is important to emphasise that this work is the outcome of a fairly long process of discussion and a formal study of several empowerment projects in different countries of South Asia. It is in fact called the South Asian Empowerment model. Every time it is presented, discussed and debated, some new dimensions come into it, and it becomes further refined, still very much in the process of evolving. It is not something perfect or finite, but a tentative exploration.

At the beginning, women were disturbed by the very loose use of the word 'empowerment' and realised that they cannot talk about empowerment or indeed understand it, until they understand and define the central term within the word empowerment, which is power. So, they try to understand empowerment by a fairly simple model which helps them to place the issue in a simple and clear theoretical framework. Understanding of power starts with a question, 'What gives rise to power?'

Here, the power that is being discussed is the social power - not about psychological power or 'shakti' but real social power - power in society. Where does it come from? Women realise that social power comes from the differing degrees of access and control that individuals or groups have over various kinds of resources. There seem to be three broad categories of resources that can be controlled and accessed to give rise to power. They are:

1. Material resources which include land and productive assets, forests, water, etc. This would also include financial resources, access to capital, credit, finance and so on.

2. Human resources or control over people's labour is very important for women because the control over their labour is a major source of their subordination.

3. Intellectual resources are becoming very important in today's context where access to knowledge and information is a major source of power.

Having got power, a power structure comes into being and operates in the following manner. Once a particular segment or group has gained a dominant position in a society, they naturally attempt to retain that position. How is that done? What gives rise to a particular power structure becoming very rigid, entrenched and difficult to break? Initially, direct forces or threats of force or violence are used to set up the power structure. In the case of women, it is known that the threat of violence, of rape or physical harassment is a very major underlying source of the acceptance of their subordinate position in society. But, more powerful and important is that the power structure creates an ideology to justify that particular power structure. And, these ideologies justify the dominance in a given group; e.g., the ideology of gender subordination or patriarchy, or any ideology which discriminates or justifies the dominance of a given race, nation, caste, class, ethnic group, etc.

So, ideology plays a very powerful role in keeping the power structure in place. How? Ideology is transmitted in that society through certain institutions which pass down the justification for that dominance, for instance,

1. The family : We know that the first level of internalising women's subordination, their inferiority as women, starts in the family from their earliest socialisation. Women themselves have been coopted into the dominant ideology and into the acceptance of their subordinate position and are key instruments in the transmission of that ideology because they socialise children into their disparate gender roles and stereotypes.

2. Religion plays a very important role too, by constructing all kinds of theories and theological bases for this subordination and domination,

3. Education systems, which carry the ideology further and,

4. The media which constructs and perpetuates dominant and subordinate images of people.

The women's movements have mounted a lot of protests against the depiction of women in the media. The studies that have been done on the depiction of the girl child or women's roles in textbooks, etc., are really all attempts to root out or challenge the dominant ideology as it is being transmitted through these institutions.

There are also structures which reinforce the dominant ideology the most important being the State itself, which sustains a given power structure. The State plays a role in aligning with the dominant forces in a society to sustain the unequal distribution and control over various resources. There are also specific structures like the market, the political and legal structures. Legal structures are a very important means by which the dominant ideology is interpreted and sustained in very real ways. There are forces of subordination which women encounter much more in the public sphere and others which are encountered in the private sphere.

If women agree with this analysis of power, what is empowerment? One way of defining empowerment is that empowerment means to challenge the dominant ideology, the patriarchal ideology in the case of women, through which their cooption into their own subordination has been obtained and by brainwashing them into believing that this is the just, right, "natural" and "divinely - ordained" social order. So, there is a need to start the process of empowerment by challenging the dominant ideological paradigm.

The second element of empowerment is in actually organising the oppressed groups in such a way that they can begin to challenge the existing distribution of resources and actually gain access and control over resources, which they have traditionally been denied. A clear example is in the area of literacy. In some women's groups, women have actually discovered whole ranges of vocabulary, whole sets of words which they have never known and never learned, and the power that these words have to express a whole range of experiences or knowledge. It is a very emotional and powerful experience, because they are gaining access to a simple resource like language over which they have been denied control so far.

The third element of empowerment and the most difficult one, is to actually transform existing institutions and structures, through the organisation of the oppressed people - and of oppressed

women - and to transform their ideological biases. The process of actually forming women's sangams, women's federations, etc., are attempts also to create alternate institutional bases and alternate structures with different value systems from which to carry out the process of challenge and transformation.

Another way of defining empowerment (the model developed by Ranjini Murthy, to which more has been added) is to look at empowerment as a process which enhances and increases women's control over several different aspects of their lives, especially the reproductive rights issue.

Here, empowerment is a process which aims to increase women's control over their 1) labour, 2) their private resources and assets, 3) public resources including productive resources, 4) political structures and institutions, 5) their own mobility, (the freedom to move wherever they want, the freedom to attend a sangam meeting, to come to Bangalore for a workshop), 6) control over their sexuality, (the right to say no), 7) control over their reproduction, and finally, 8) control over or rather the right to physical security, 9) 'body integrity' meaning freedom from rape, sexual harassment, physical violence, domestic abuse, etc. Actually the two models are not fundamentally different.

Having examined the three main goals of empowerment it is clear that empowerment really seeks to enhance women's autonomy and decision making power. It is not known whether the women are very comfortable with this word 'autonomy'. Like empowerment, it is another term that can be very confusing. What does autonomy really mean and how is it translated in an Indian language? For instance, in Mahila Samakhya, the term '**Swantha Nirdhara**' or the capacity to make your own decisions is used. So really, autonomy comes very close to the notion of the capacity, the right and the freedom to make your own decisions. The dictionary definition is the right to self government, which is very appropriate, because in a sense it means,'I want to govern myself', 'I want to decide for myself and be my own person'.

What is the process and what are the elements of the process of empowerment which can bring about this kind of transformation in women's position? Some of the key elements of this process are examined. First of all, it is very clear that empowerment is not something that can be left at an individual level. It is clear that the kind of process and the definition that we are talking about is a very political definition. It is not talking about transformations in the life of an individual woman. It is clear that individual women are able to assert their power in many different contexts and have done so throughout history. But,what is being talked about is a process which mobilises women into collectives, which organises them to form associations or forums or organisations. These organisations begin to have a visibility and bring women out of individual isolation into formations which can then begin to attack the dominant power system or negotiate with it in a far more visible, organised and powerful way.

Second, it seems clear that in most situations, empowerment is something that has to be externally induced. It is a process that is triggered off or stimulated or catalysed by a force coming from outside - individuals, activists, organisations, etc. It is a process that is multipronged and because many people believe in a "single cause" theory of empowerment, stress is on the fact that economic empowerment is the root of everything. Give women some income, some control over their income and everything will be alright; Or, that education is the root of

empowerment, so make women literate and everything will be fine. Why is it then that the highest rates of dowry deaths, for instance, are among the lower middle class and middle class in this country which are the so-called educated group? Why is it that even when women are earning a lot of money, they continue to be subordinated in many other ways?

It is quite clear from the first analysis of power that as long as the dominant ideology is pervasive, as long as women themselves are coopted into this kind of consciousness and acceptance of their subordinate position, no amount of economic power, no amount of education or literacy per se, no amount of improved health in itself, is going to empower them to challenge this. So, it has to be a multiple process. Any one engaged in empowering women has to sit down and examine the following :

* What are the elements of one's work that look at ideology ?

* What are the elements that look at resources ?

* What are the elements that deal with transforming institutions and structures in society ?

Another interesting aspect of empowerment is that it is a spiral. It is not a linear process. Women take ten steps very rapidly and then, due to some kind of a backlash or an internal crisis, there is retrogression.

Another very important aspect of empowerment is that it should generate new notions of power. Changing styles of leadership are experimented with. Instead of having a single person leadership, which is a very classic patriarchal leadership structure, collective and rotating leaderships are tried out. All these are attempts at creating new understandings and new ways of dealing with power.

Of course, empowerment is a political force. Anyone who says that empowerment is not political is not talking about empowerment! Most important, empowerment should lead to something more than the formation of small local level organisations, to a national movement. A lot of organisations, NGOs involved with empowerment, reach a kind of a stagnation point. They say that we have formed our sangams which are very strong and women have become very vocal and are tackling a lot of issues locally and so there is no need to move further ahead. But this attitude will not lead to transforming that district or area nor is it going to change government policies. To become a real political force, these small groups of women - the sangams or mandals - have to federate themselves, associate and become part of a much larger mass movement to bring about real and lasting changes in the power structure.

To conclude, the implications of empowerment for reproductive rights are quite obvious: Women are trying to bring about a situation where they can move out of a position of having no rights or no consciousness of rights. Their consciousness hitherto had been built on duty, obligation and responsibility to the family, to the community, to the clan etc. Now they must reach a position where they have a consciousness of their rights, are able to articulate and recognise needs, including reproductive and other health needs, which they may not have even conceived of, prior to this process of change which is called empowerment.

Empowerment by creating these organised fora of women which strengthen and reinforce each other, also gives women a very practical source of strength for asserting their rights. Recognising rights is only one part of the process. However, the capacity, the strength and the confidence to actually assert those rights and exercise them, cannot always come from the individual. It is important to note that groups and movements can support women to assert those rights.

Women must exercise two cautions when they are looking at the question of empowerment and its implications for reproductive rights. The fact that becomes clear and applicable to the whole of South Asia is that, the empowerment process impacts much more quickly in women's interactions in the public sphere than in the private. They are more ready and willing to take on lack of water, housing problems, child care, health care, the school not running properly in the initial phases than they are to take on questions like sexual abuse at home, domestic violence, or of sexuality, sexual relations and reproductive relations between husband and wife. So, the empowerment process cannot be expected to impact very quickly in the private sphere, because as Vasantha Kannabiran said, 'The family is the last frontier of patriarchy and it is the most difficult one to penetrate.' Empowerment processes do penetrate that frontier but it takes time. The second caution is that there has been a tendency to instrumentalise the empowerment process and think that the whole population control agenda can be converged with women's agendas through an empowerment route. Experience has shown that empowerment definitely is not a panacea for all ills. It is not something that can be given like a pill to produce the right results. It does definitely impact on women's reproductive behaviour, on their concept of their own rights, over their bodies, but not at their chosen time or in their chosen way. It comes about as a result of women's own decision. Empowered women will determine their own agendas in creating a more just world through the empowerment process and their reproductive rights will definitely be a part of that agenda.

Questions and Responses

Q : What is the role of the man in a situation where a women is trying to take away the power from the man and he does not want to give it? We are not touching at all on the role of man.

R : I will give a very quick response to this. We have come to two or three conclusions about the impact of women's empowerment on men.

The first is that there is no escaping the fact that women's empowerment, does involve the disempowerment of men. Because, if we know what is the dominant ideology and what are the dominant social arrangements that subordinate women, then we know that one of the key things is the gender division of labour. This dictates that women carry this triple, double, or quadruple burden, and obviously, a women's empowerment process is going to challenge the distribution of work, particularly in the household. It is going to challenge the kind of stereotyping of gender roles.

In response to your question, I would like to narrate an incident involving one of the project leaders from Bangladesh who spoke very passionately about women's empowerment after which he said to me, 'All that is very well, but if I go home and my wife won't give me a cup of tea, I don't think that's women's empowerment.' This is exactly what women's

empowerment is. That she can say, 'Get your own tea.' Or that you expect that because she is your wife and is a woman, she has to make you tea. So there is going to be a loss of power in this very limited sense, where men have exercised power over women's labour. You cannot say there is empowerment, if that does not change.

On the other hand, it is also true that a process which empowers women because it is also addressing all kinds of subordination, domination, and discrimination, has a tremendous potential to liberate men. I do not know of any grassroots' women's empowerment process in which men have not been participants. They always have, and women gain men's participation in different ways. Sometimes, through cajoling, sometimes through fighting, sometimes through collective force. Over a period of time, men begin to see that although this process is disempowering in certain narrow ways, it is also a tremendously liberating force.

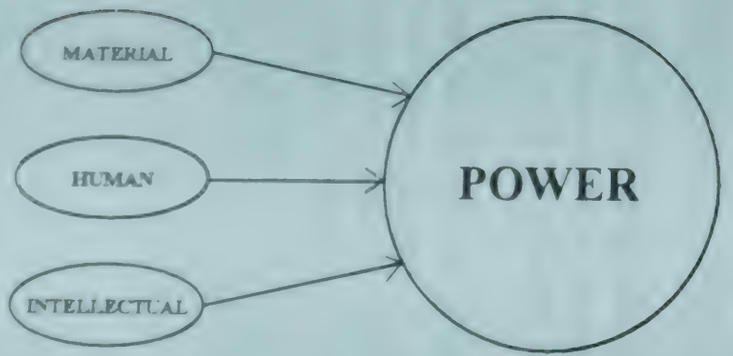
Men in communities also instrumentalise it. What is happening is that as long as the women's sangam is running around and getting a handpump repaired and the school running properly and getting resources out of the Panchayat, etc., men are very supportive. They love women's empowerment, because as those men in Banda district at the Mahila Samakhya programme said, 'Aur kariye Bahenji, hum ko badha aram hai! Aur kariye!' Because now, the women have become handpump mechanics, they have got the whole water system in Banda district working after 25 years and the men are saying 'We are very happy, please do more, because we are enjoying the fruits'.

The other question that comes up is, 'Why are you not directly working with men in empowerment?' I am not saying that we do not. Some people may choose the strategy where they are simultaneously working with men in the community. But equally successful have been strategies where the women are being organised, and in turn, as women educate the men and raise the men's consciousness. It is not that the process is not affecting anybody else because we are working with women. It is constantly rippling and spreading into the entire community.

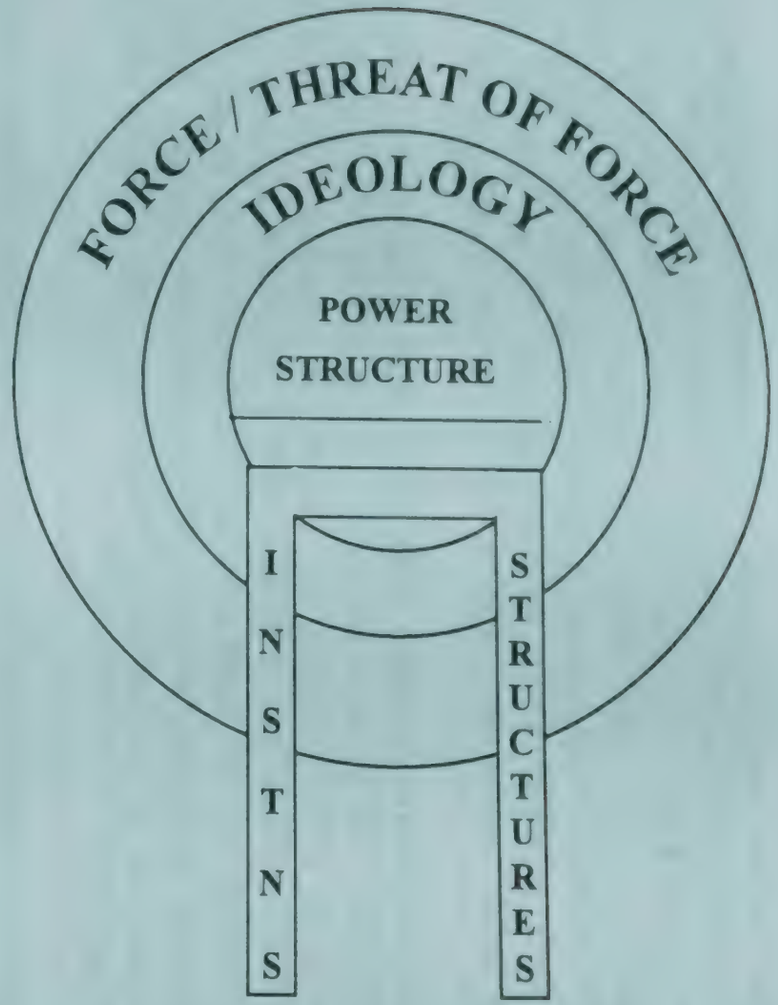
Q: When we talk about reproductive health and rights of women and population, the term population implicates both men and women as both are equal partners while reproductive health brings the onus on to the shoulders of women. How do you address this question?

R: A valid point is being raised, but I wondered whether we are tending to assume that when we say 'women's reproductive rights', it actually excludes men. In fact, women's reproductive rights do not exist independent of men. If women are to have reproductive rights, it essentially means the participation, cooperation, partnership, of men. It all depends on what meaning we give it and how we give the content of what we call reproductive rights. These reproductive rights cannot exist outside reproductive relations which is between men and women.

UNDERSTANDING POWER



ACCESS AND CONTROL OVER RESOURCES



FAMILY
RELIGION
EDUCATION MEDIA

ECONOMIC
POLITICAL
LEGAL

Part II

LEGAL AND POLICY FRAMEWORK IN INDIA

CHAPTER 5

LEGAL AND POLICY FRAMEWORK IN INDIA

Anika Rahman

A research programme conducted in India, with the assistance of certain Indian lawyers on the legal and policy framework sheds light on various Indian laws. India has a vast number of laws which are not enforced and most people do not have access to the legal system. Yet, the law remains important. One way of helping to focus on these issues is to talk about laws and rights that relate to reproductive health care. If the reproductive rights are defined to include issues of autonomy and self determination and the ability of women to decide what to do with their bodies, then there is a whole range of laws starting with marriage laws, custody laws, inheritance laws and rape laws all of which affect reproductive choice and are directly related to the issue of reproductive rights.

This paper will focus on laws relating to reproductive health care services. The issues of rights in terms of control over one's body will also be raised.

I will primarily deal with Central Government's laws. There are innumerable laws at the state level and our research is in its first phase. Hence, those laws that are generally applicable to all of India will be discussed. Most laws make exceptions for Jammu and Kashmir and some make exceptions for other states.

I will look at the rights issues closely and my discussion will focus on the rights relevant to women in the delivery of services or in being able to access these services. I will refer to the laws that already exist and the laws that ought to exist to provide women with their rights. But just having the law is no solution unless it is enforced. Women must have access to the legal services and these are the inherent limitations of a legal system, especially in Southern countries like India.

A good way to begin this discussion and to engage everyone in it is to narrate a story that would bring out some of the issues relevant to the present context.

There is a woman named Kamala living in a large city in India. She is a middle or lower middle-class woman and gets married at age 18 to an accountant. When she gets married, she has no idea of the various contraceptive methods that exist and nobody imparts the information that she needs about contraception. On her wedding night, her friend gives her a packet of pills and tells her how to use it. Kamala does not know that she has to take one everyday and can get pregnant if she misses it even for one day. Twelve months later, at age 19, she gives birth to a daughter. At this juncture, she is not aware that she could obtain an ultrasound.

As they are a young couple starting out in a big city, she decides to delay her next child by using contraceptives. In her case, she chooses the pill. As you know, the pill is not fool proof. Even with regular and correct use, there is a ten per cent chance of getting pregnant. Twelve months later, she gets another daughter at age 20. Then, she decides to do something as she

has become a mother of two daughters at the young age of 20. So, she decides to go to a doctor to find out why her contraceptive method failed. She goes to the doctor/clinic/nurse in her neighbourhood and requests them to guide her in the correct usage of the contraceptive. It is not certain that the medical provider gives her all the options. The doctor informs her about long term contraception like DEPO but she decides against the long term method. So, they advise her to use the pill but this time with an explanation about the correct usage and warning her that it is not 100 percent guaranteed. She obtains her pills.

She starts to get dizzy, nauseous and does not know why she suddenly feels unwell in the mornings when she gets up. She attributes it to weakness acquired due to the two children and the load of housework. She is unaware that the pill may not be appropriate for her at this point as, after two births, her body may have changed.

Despite headaches, she continues to use the pill correctly but is suffering silently. After about 15 months, she misses her periods and waits to see if it was just a fluke. When the second period is missed, she suspects pregnancy. Now she decides to continue her pregnancy only if it is a boy. Her mother-in-law agrees with her that they need a son. Her husband also wants a son as he cannot relate well to his daughters. The mother-in-law insists on her making sure that it is a son. What does she do?

She sees an advertisement on the wall, while travelling in the bus, that offers tests to identify the sex of the foetus. The advertisement mentions the name of the clinic and its phone number. She telephones and makes an appointment. She is told to come later when she is in her second trimester. This was because she cannot undergo the ultrasound test in her first trimester. She returns to take the test two and a half months later when she is about 15 weeks into pregnancy.

A few days later she is told that she has a female foetus. So, she decides to terminate her pregnancy. Though she is uncomfortable about her decision, she knows that her husband is not making enough money to support another daughter. Hence, she can only have a son.

She knows that she can have another child any time in the future and decides on the private doctor who is going to perform the termination of pregnancy for her. She decides against going to a big hospital. The private doctor does not question her decision at all. She says that the conception occurred due to the failure of the contraception. She fixes an appointment and gets her medical termination of pregnancy done.

The abortion, because it is in her second trimester, necessitates a surgical procedure. During the procedure, when she starts haemorrhaging on the table, the doctor gets very nervous and decides to give her blood transfusion to make up the loss of blood. She gets HIV infected blood during this transfusion, but she is unaware of it.

The doctor decides that the best course of action will be to remove her uterus as she is haemorrhaging at an alarming rate. As she is still unconscious he does not inform her. The husband who had accompanied her is told that his wife is going to die unless this procedure is performed

The husband is a little concerned, as there are two daughters at home who need to be looked after right now. He tells the doctor that he can do anything save her life.

The story is going to be stopped at this point so that we can talk about the women's rights issues that relate to reproductive health care in this scenario.

Questions

* **What should the law address in this situation?**

* **How would you expect the law to be OR what would you say the law should be?**

* **What are Kamala's rights issues in this case?**

* **What are the general women's rights issues in this story?**

Remember, right now Kamala does not have her uterus, she does not know of this loss and she may be HIV positive in the future.

* **What are Kamala's remedies?**

* **At which point should the law have been involved in this story?**

Responses

- "The blood bank should test the blood for HIV/AIDS before it is given to any patient."

- "The status of the blood bank is not known yet. All that is known is that it provided the clinic with infected blood."

- "In Karnataka most of the blood banks have that facility. They do not take any donor. A relative has to donate blood and the blood is tested."

- "The blood banks should be sued for not providing blood immediately and the doctors who are treating the woman should organise everything before operating on her. Foreseeing the risk is the professional responsibility of the doctors."

- "The blood bank and the doctor are liable."

- "There must be some law provision pertaining to the failure of contraceptive techniques such as pills."

- "In a country like India, it should be illegal to sell pills everywhere with no person administering it. The prescription must go through a physician, so that, if something goes wrong, the physician can be held responsible."

- "The pill is an over - the - counter drug."

- "Was the pill the only option? Could Kamala have used the loop? Was she given adequate, necessary information ?"

- "Kamala has a right to information."

- "Where would Kamala have got the information from?"

- "Information has to be a continuous process. She has gone in for a service. As the whole chain started with her purchase of this contraceptive, the information should have begun with an adequate warning there. Relevant information like the percentage of failure should be provided. In this country, no counselling is given regarding the use of contraceptives. Everything is done on a very personal and an individual level of awareness, which may be good or very bad. The next liable person is the doctor who advertises the prenatal sex determination test. He has a responsibility to give information about his techniques and the impact it is likely to have on her body."

- "She should be made to understand that there is a likelihood of haemorrhage occurring as she is in her second trimester. If she had had the information, she would have taken a volunteer from her family for blood donation in the event of her needing blood. And women are so anaemic that at times they are a surgery risk."

- "When information is given about contraceptives, only the good things about it are mentioned in a colourful way. No information about the bad and side effects are given. And anything can happen at any time of the period, at six months or three years. The person supplying the contraceptive should be sincere enough to also give the bad side of the product and do a follow - up on that particular person. Sometimes it may be discovered after two months that the particular contraceptive does not suit the person."

- "The woman should choose whatever contraceptive she wants to use. Other methods such as IUD or sterilisation should not be dumped on her."

- "The age group chosen i.e. 18, 19 and 20 is a stage when nothing is known about sex particularly in the Indian context. There is no sex education and absolutely no awareness of sexual matters. As there are a number of girls' schools in our country this point could be addressed there. Sex education could have prevented a lot of what was mentioned in the story."

- "All the while, her right to choice through awareness of information has been violated by various factors and various people in the drama. This is a violation that women face throughout their lives across countries, cultures, times, etc. So how far can any legislation help? Or do we need other agencies to help make an informed awareness choice, for all women? And to that extent, could legislation help at all in addressing many of the violations that women face throughout their lives?"

- "It should be made mandatory for the pharmaceuticals to have complete written information along with each package of the pill. Then, she would have read about it. The second point is about the clinic's sex determination test. There should be a regulation to curb these or they should be registered, to be able to practice the sex determination tests."
- "The basic situation arose due to the feeling of the family that they did not want another girl. There is a very grey area in the legal situation. The point is that she went in for the abortion purely and simply because the technology available made her aware of the fact that the foetus inside her was a girl. How she handles that knowledge is determined by other factors which are very difficult to legislate."

- "The medical profession is now under great controversy, as it is now being accepted that it may come under the Consumer Protection Act. But government hospitals and the doctors there are considered as free services so they do not come under the Act. All medical practitioners, including licensed medical practitioners, etc., should be brought under the purview of the Consumer Protection Act."

- "Even the husband should take responsibility of this woman's life. Somewhere, this issue needs to be addressed, otherwise, this repeated pregnancy and the risk of life cannot be solved."

- "Before operating on her, did the doctor conduct a thorough checkup of whatever was required? Second, did he explain to her the various consequences, implications of the choice that she was making? Third, after the operation was completed and she was out of the hospital, was she provided with all the hospital records and given an explanation of what had happened. If there is no legal access to hospital records then one cannot really sue for malpractice."

- "The issue of total health care, and not just reproductive abuses, should be looked into. Otherwise, it becomes impossible to decide as to who should be penalised. The matters of lack of information and inadequate information should be treated in this country or any other country with care. The whole state should be made responsible."

- "The **Sinologist** should have informed her about the dangers she is going to face by aborting the child in her advanced stage of pregnancy. She should have been advised about the advantages of knowing the sex of the baby as compared to the risks of abortion at a late stage of pregnancy. She should have been helped to determine her priorities properly as to whether it was important to know the sex of the baby or have an early safe abortion. It also would have enabled the family i.e. the husband, in-laws and all others concerned to realise that the daughter-in-law is facing so many risks."

I note that many of the laws that apply to the right to informed consent or information counselling, would be laws that should apply across the board to health care. If there were laws that applied to all health issues, it would apply in this situation as well. But there are no such laws in India.

Laws, obviously, should not be confined only to reproductive issues within counselling, information and health care. It should cover all issues.

Issues

* **Was Kamala married at a legal age?**

The discussion will now cover the laws in India. There is, for example, a Child Marriage Restraint Act, under which the legal age of a first marriage in India for women is 18 years and for men it is 21 years. Hence, if Kamala of the story was 17 years old when she married somebody who was 22, that, in terms of the Act, would be an illegal marriage. We all know that many women get married before the age of 18 years and the law is not enforced. This is another problem and a limitation of the law.

Kamala also lacked sex education. There are no central laws in India regarding sex education. There are guidelines for curriculum published by the National Council for Education, Research and Training (NCERT) for sex education in certain situations. So they have, for example, what they call a National Curriculum for elementary and secondary education, which was issued, according to our research, in 1988. That talks about the importance of telling people about the small family norm and educating them on the problems of population. But, it does not talk about informing a woman as to how to deal with sexual health and what sex is all about fundamentally. NCERT also has some guidelines on the minimum content of what population education should be. And, again, it talks about the problems of a growing population. It does say that there should be discussions on what they call ' human reproduction ' (words quoted from the publication), contraception, the need to delay marriage, spacing of births and the importance of women and equality of women. But these are just guidelines again. They lack the power of the law and hence they are not enforced even for the public school education system.

* **Did Kamala consent to her sexual relationships with her husband? If not, what does the law state?**

When we talk about the health needs of women, we need to raise the issue of her consent to sex. For example, let us discuss the problem of alcoholism. If the husband comes home drunk and forces the wife to have sex with him, she may not want to do so. Now, Indian law does not provide you with protection on that issue. For example, forced sex with a strange man is considered rape, a shame and clearly a crime as everyone would agree. But, if that man is the drunk husband, who is forcing the wife to have sex, it is not recognised as rape in this country by the law.

Other countries recognize the crime of marital rape. But in India, there is this specific exception that forced intercourse within marriage is not rape unless the girl is below the age of 15 years. If the man happens to be married illegally to a 14 year old and forces her to have sex with him, then it would be construed as rape. But if the wife is above the age of 15, that is not rape.

So, where is the issue of her sexual relationships with her husband? The law does not provide her with protection against rape within the marriage, unless it is defined as being domestic violence. Then the issue of assault could be talked about, along with battery and cruelty would come into force and criminal laws would apply in such a case.

Even if the law recognised marital rape, there would be enormous social and cultural barriers to a woman coming forward and admitting that she is pregnant as a result of being raped by her husband. Neither her mother-in-law nor her father would heed her words. Everybody would advise her that since she is married, she has to sleep with her husband as and when he wants her to sleep with him. So, even if the law is enforceable, it is purely hypothetical unless there is an enforcement mechanism - like the police system, lawyers and judges - that is gender sensitive. The problem of women all over the world is to come forward with something that is so culturally sensitive.

* **Does Kamala have a right to appropriate health care under the law?**

Remember that she got a package of pills on her wedding night from a friend. Being a middle-class woman who is married to an accountant not working in the government, Kamala is not eligible for the free services of the government, but does she have a right to health care ? She is not a marginalised poor woman. Hence the answer is 'No'.

There is a section of the Indian Constitution, namely, Article 47 of the Directive Principles of State Policy, which says that the state has an obligation to raise the level of nutrition and the standard of living of its people. But, the Directive Principles in the Indian Constitution are what are legally referred to as 'non - justiciable', which means that a claim cannot be brought in court on the basis that the government has not fulfilled those obligations. These principles are simply a political statement of the objectives of the government and its goal in the future.

Input

- "The right to health has been incorporated in Article 21, and that is a very important development. The right to health includes the right to life and liberty under the Indian Constitution. Constitutional litigation is not the best means. Women should work with what is available at present while pushing for the law reform. Effective learning is possible from the realm of education rights in India, where a similar debate came up and it was made clear that the government cannot be forced to provide facilities for education that comes under Article 21."

The problem with all governments, including the Indian government is that enforcing the right to health care involves the mobilisation of enormous resources that most governments are not willing to undertake. It is highly unlikely that any Supreme Court would impose such a requirement on the public sector at least. The law can regulate the provision of private health services but they would not impose such an obligation on the government in these times.

* **Did Kamala have the right to counselling about contraceptives under the principle of informed consent which includes the idea of counselling ?**

The principle states that one must be counselled on the range of options available and must be told what the side effects are, how they are likely to affect the body and then allow one to make the choice. The issue about the extent of her knowledge about the risk of a second trimester abortion has also been raised. Was she informed about the risks of an ultrasound, if any ? So, these issues of counselling will run through her life and the lives of other women

whenever women interact with the health care system and not just in reproductive health. In all situations, she should have all the rights that relate to counselling and all other relevant information required in that medical situation.

In most countries with a similar legal system as in India, the right to informed consent is usually created by the courts. It is not usually a right that is contained in a legislative enactment. Now in India, there is no overall right to informed consent in all conditions, but there are exceptions. For example, the **Prenatal Diagnostic Technique Act of 1994** requires the patient to sign a consent form before undergoing ultrasound, which states that the patient has been provided with the information necessary for that decision and that the decision is the patient's choice. But we do not know much about the enforcement of the law that has just been published in the official gazette - the **Prenatal Diagnosis Act of 1994**. The government has yet to provide rules and regulations.

There are other guidelines stipulating that every time a sterilisation is performed, a consent form has to be signed or you are to be thumb printed. A consent form is an entirely different proposition from informed consent. Informed consent includes counselling so that the patient understands her actions, and just getting people to thumbprint a form does not mean informed consent. There are no such requirements of informed consent when it comes to a MTP. The law does not require it. No court created principle entitles one to sue on the basis that an overall consent has not been given.

*** What laws regulate contraceptives such as the pill?**

The issue of information regarding the contraceptive pill should specify the content of the information leaflet provided with the pill. It should include what is contained in the package, the risk factors involved, and the possible percentage of the risk of pregnancy as no contraceptive is 100 per cent perfect. It should also inform the user of possible side effects and contraindications, if any, in the case of specific patients such as blood pressure patients preferably in all languages. India is a country with a diversity of languages.

In India, the answer is not clear. The law in India does not specify the content of information and the type of information that should be provided with any kind of drug or medication. The law does not regulate a lot of information.

The Drugs and Cosmetics Act of 1940, in India regulates all drugs. It also requires regulation of blood banks. This is a 'catch all' law that deals with all these situations. But it does not tell you how and what information should be provided to a consumer. So, the law permits the information on the package of **ECROS** which does not mention anything about the contraindications. Some oral contraceptives do provide this information. This instruction again depends on the quality of the contraceptives. The ones that are being provided in government health care centres do not often have the instructions. There should not be a situation where middle class men and women who can afford contraception are getting the insert and government clinics are not providing the insert. The insert is not a mandatory requirement under the law.

The law is silent upon an issue on which it should speak. This is an area requiring regulation

*** Did Kamala legally access ultrasound technology ?**

There is what is called the **Prenatal Diagnostic Techniques Act of 1994** that came into effect just recently. This law applies to the whole of India, except Jammu and Kashmir.

Kamala was travelling when she saw the advertisement regarding an ultrasound on the wall. Under this law, it is illegal to advertise genetic counselling centres. The name of the law is **Prenatal Diagnostic Techniques Regulation and Prevention of Misuse Act, 1994.** Basically this law says that it is illegal to use what they call 'prenatal diagnostic techniques' in most situations and specifies the conditions under which one can undergo the prenatal diagnostic tests. It says that prenatal diagnostic techniques like ultrasound, analysis of amniotic fluid and chorionic villi, could only be conducted when they are done for the purposes of detecting certain abnormalities such as chromosomal abnormalities, sex linked genetic diseases, congenital anomalies, which means inherited diseases. Only certain kinds of persons, that is women, are qualified to take these tests.

A woman can only legally obtain an ultrasound under very limited situations:

* The woman must be over the age of 35 years;
* The woman must have undergone two or more spontaneous abortions or foetal loss;
* She must have been exposed to potentially **teratogenic** agents, that is, drugs, radiation and chemicals;
* A family history of mental retardation or physical deformities; and
* Other requirements.

So, to get a legal ultrasound test, one must be a woman over 35 years. Kamala was 21. Also, since she did not fit into any of the conditions mentioned above, she did not meet the requirements of the law. In the event of mental retardation in the family, there is a eugenic provision in the law. In such cases, the government is regarded as having an interest in ensuring that women do not produce children with mental retardation. The presence of any mental retardation attributable to genetic causes will make a woman eligible to take the ultrasound test legally. The **Prenatal Diagnostic Techniques Act** regulates the provision of ultrasound services. The Act mentions specifically that the ultrasound should not be performed except in particular situations for certain women. For example, older pregnant woman can request a legal ultrasound. If the doctor is a good one, he will ask her the reason for the ultrasound. If he gets a reply that it is because she does not want a daughter, he should refuse to do it under this law. The law would regard that as a criminal act if he went ahead and performed the procedure for the purposes of sex determination. He would then have to pay a certain fine and could also be imprisoned.

Let me give you another example. A 40 year old woman requests a scan on the basis of a sex linked disorder in the family and shows documents to prove it. She thinks that the child may have a hereditary disease. If the doctor performs a scan in this case, it is legal. A scan performed to detect certain specific abnormalities is legal. Advanced maternal age itself makes it legal to obtain a scan as there is an increased risk of having babies with diseases. All other criteria are valid for lower ages.

If a woman is over 40 years old and is concerned that her fourth child may have certain abnormalities, the decision of offering the services to her will have to be taken after considering all the objectives listed. This is done to determine the possibility of detecting abnormalities in late - term foetuses. Now, is it legal to provide her with the scan? These issues can be decided only by the doctors who understand what congenital anomalies mean and whether a woman over the age of 35 years can have a problem with the pregnancy.

If, on the other hand, she is 19 years old with a congenital heart problem and she wants to make sure that her child does not have it then the law would also consider the performance of a Prenatal Diagnostic technique to be legal.

* **If someone approaches the doctor and tells him that there is a history of insanity in the family but without any documented proof what should be done? What does the Prenatal Diagnostic Techniques Regulation and Prevention of Misuse Act 1994 say?**

  The law cannot regulate everyday social patterns. That is the problem.

In the area of health care, whether it is reproductive or otherwise, the doctors who are the final arbiters of these questions, must decide whether the patient falls within these categories. That is the discretionary power of the doctor, the medical provider. In the final analysis, the decision rests in his/her hands.

The other relevant thing in the Act is that the Act requires informed consent. It requires the doctor to counsel the woman on the side effects of a prenatal diagnostic technique. If it is not done, the law will hold the doctor liable for that lack of counselling.

We do not know the side effects and after effects of a scan. Unless that is known, the provision of informed consent is useless here except when the doctor is talking about the risks of a second trimester abortion and the complications that may arise from it. These will be much greater than the complications of a first trimester abortion.

The law fines and places criminal penalties upon doctors who do not follow the law. The penalty is five years in prison and a fine of up to Rs.10,000. Then the doctor would be reported to the State Medical Council and the name of the doctor will be removed for two years from the Medical Registry for first violation. If the doctor violates the Prenatal Diagnostic Technique Act again, and his violation is reported to the State Medical Council, he will be permanently removed from the Medical Registry after which he will not be allowed to legally practice medicine in India.

But the law also holds the woman guilty for choosing a sex selective test and the woman herself is punishable for imprisonment up to three years and a fine again of Rs.10,000. The only exception is in case of the woman being compelled to take the test. But what constitutes compulsion ? Is she being pressurised by the mother-in-law or the husband or anybody else? Even in cases of compulsion, the law does not seek to imprison or to deal with the people who compelled her. It only penalises the woman. In Kamala's case, for reasons of shyness, if the husband had gone to the clinic and requested that the procedure be done for his wife then the question of legal liability and imprisonment of the husband arises because he is the person

who went to the clinic and sought the aid of the clinic. If the mother-in-law goes with her daughter-in-law, it cannot be said that she is somebody who is seeking the aid of the clinic, as she is just there to help her daughter-in-law. So it is a very grey area and it is unlikely that the mother-in-law will be caught, unless the husband goes before hand and specifically tells the doctor to set up an appointment and do the procedure on his wife in which case he is covered by the law.

Input

- "One clarification: Section 24 of the Act says that there is an initial presumption that the woman was compelled to undergo such a test. The exception is the proven reality that she was not compelled to undergo the test. There is a presumption in place. How enforceable that presumption is, is another issue."

* **Did Kamala obtain a legal abortion?**

According to 1991 and 1992 figures, the number of legal MTPs was supposed to officially be 0.6 million or 6 lakhs. During the same period, it was estimated that a total of over 11 million i.e 110 lakh abortions occurred in India 70 lakhs of which were induced abortions. So 10 per cent of all abortions in this country are considered legal and 90 per cent of them are illegal. Kamala had an illegal abortion. According to latest estimates, there are about 15,000 - 20,000 abortion - related deaths in India every year.

The law pertaining to abortions is the **Medical Termination of Pregnancy Act** of 1971. It requires that medical registered practitioners with specific medical facilities provide MTP services. So, in Kamala's case, the question that arises is, was the doctor to whom she went for the abortion a registered medical practitioner in terms of the MTP Act itself ? All medical practitioners are required to be registered, pursuant to the Indian Medical Council Act. For example, a spurious doctor will not be registered. Not all clients who walk into the clinic are going to ask to be shown whether the doctor is registered under the Medical Practitioner's Act or under the Indian Medical Council Act. Most do not ask that of a doctor. It is just assumed that a doctor who poses as a doctor is a doctor. Nothing is known about the doctor who attended on Kamala. It is an open question. It needs to be ascertained whether that doctor was a registered medical practitioner.

The next question is, did the government approve the facility where she obtained the abortion? Did the government approve that clinic or hospital for MTPs? The rules of the MTP Act (1975 Rule) say that the hospital must have an operation table, anaesthetic equipment, drugs and some ventral fluid. So, we need to ask two questions. Was the doctor registered? Was the facility approved? If the doctor is registered correctly and if the facility has been approved by the government, then the possibilities are that the abortion was legal.

But moving on, Kamala was 15 weeks pregnant. Now, the law states that if the pregnancy is between 12 and 20 weeks, two doctors are needed to verify that this woman is eligible for an abortion. India has one of the most liberal abortion eligibility requirements in the world and the grounds are:

* That the continuation of the pregnancy would involve a risk to the life of the pregnant woman or grave injury to her physical or mental health.

* That where pregnancy is caused by rape, it is assumed to cause injury to mental health.

* Where there is substantial risk that the child born would suffer from physical or mental abnormalities.

* Failure of contraception is regarded as a valid ground for an abortion.

As Kamala had a failure of contraception, she is eligible. Now, the law says once it is determined that the woman is seeking a MTP because of either rape or failure of contraception, the gestational age of the foetus has to be determined. In other words, if the pregnancy is within 12 weeks, then she needs only the consent of one medical practitioner. But Kamala was in her second trimester. Hence under the law, she requires two doctors to give consent to the MTP. In Kamala's case the required two doctors were not present when the decision to go ahead with the MTP service was made. So, on this ground alone, the abortion becomes illegal under the provisions of this act.

So, the answer is she had an illegal abortion. But the law is never enforced or followed by medical providers which accounts for 70 lakhs illegal abortions in India. Clearly all the doctors who performed these MTPs have not been prosecuted.

*** Were Kamala's rights violated when she obtained infected blood?**

Central blood banks, clinics and hospitals have an obligation to make sure that they have untainted blood. In India, the Drugs and Cosmetic Act requires HIV testing of all blood supplies. But it is not clear what occurs when this law is violated.

However, Section 314 of the Indian Penal Code, states that if one causes the death of a person by negligence then that person is criminally liable for that death. But until Kamala dies, this criminal claim cannot be brought. So what can be done ? It can be said that the clinic should have made sure that they had untainted blood. A claim of medical negligence can thus be made on the basis that the clinic was negligent in not providing Kamala with clean blood.

*** What are Kamala's rights vis-a-vis her botched abortion?**

Kamala may have a claim under the **Consumer Protection Act of 1986**. When citizens pay taxes, this money is supposed to be used to provide education, health, build roads, schools, and all other things. It can thus be said that the government has been paid some money for all these services. Then the people become consumers of government services. But the Commission set up by the Consumer Protection Act says that you are not a consumer of government services and the Consumer Act is supposed to only cover the specific situations in which you pay money for services. Remember that Kamala went to a private doctor. If Kamala paid the doctor for his services, she can sue him for performing a botched abortion under the Consumer Protection Act.

Input

- "It is not that there are no standards for other people who fall outside the Consumer Protection Act. There is the whole concept of negligence and even government servants do have a standard of care against which they are judged. So, it is not that a government doctor cannot be taken to court, etc. What defeats one is not even the fact that the **TORT** law is not so well developed. **Tort** law should be developed in this country and it is not a difficult area to enter into. What defeats everybody is the inability, apart from the impossible court system, to get evidence and the inability to get information. There is also the disadvantage of the laypersons not reading and understanding the law".

- "Because, if you are an NGO working in that area and when something is said about providing specific medical facilities you think about what is the reasonable thing in a case like this and will hold yourself to that standard. A reasonable personal standard is what you should be looking at and if your common sense says, where this man has been performing abortion after abortion without an I.V. drip or a sterilisation kit, then you can catch him. If you go with that front, you would be more empowered than if you worry about the whole mystique of the law".

Another major impediment to bringing a negligence claim is that high court fees have to be paid. The Consumer Protection Act and the system it sets up is free, so if a claim for Rs.25 lakhs is made, nothing needs be paid, but the papers have to be filed appropriately. But generally, in civil courts in India, when a claim for damages is filed, a certain percentage of the claim has to be filed with the court. In the case of a claim for Rs.25 lakhs, unless a waiver is obtained, there will be requirement to pay the court fees amounting to Rs. 50,000. Then it is a big impediment to bring a civil damages law suit.

There are several other key laws and policies that are relevant to what is under discussion. I will describe some of these briefly.

First, there are numerous laws that regulate the qualifications of health care providers. Central government laws oversee medical training institutions and provide for the registration of all medical practitioners. Laws - such as **The Indian Medical Council Act of 1956**, the **Indian Nursing Council Act of 1947** and the **All India Institute of Medical Sciences Act of 1956** - regulate qualifications for health care providers, medical institutions and medical professionals. But there is no "quality control" of medical institutions.

Second, the licensing of medical professionals is another key matter. There are a number of different laws which govern the licensing of modern doctors and nurses. For example, the **Indian Medical Council Act of 1956** established a medical register of all modern medical practitioners in India. In theory doctors can be removed from this register. Yet, in practice, this is an extremely rare event and we could not find documentation of it occurring even once. Nurses are also regulated to the extent that they have to be registered under the **Indian Nursing Act of 1947**. But again, if a nurse does not perform her functions, removal from the registers is not known to occur. In addition, practitioners of traditional Indian Medicine are not regulated. This is a big problem because it is known the majority of Indians consult with traditional practitioners.

Third, Indian law does not adequately regulate contraceptives. There are no clear legal or medical standards by which to determine if contraceptives ought to be mass marketed. Also, there are no clear requirements about what information should be provided to users of contraceptives.

Finally, there is no Indian Central government law regarding sterilisations. This absence of law is a serious problem in a country in which 72 per cent of all contraceptive users rely upon sterilisation as a form of birth control. The Central government has issued guidelines regarding how sterilisations ought to be performed and on whom, but these guidelines do not have the formal weight of law. Of course, if death results from a sterilisation procedure, a criminal case can be brought under the Indian Penal Code. If problems arise from a sterilisation performed in a government clinic or hospital, a civil claim for monetary compensation cannot be brought under the **Consumer Protection Act.** One could think about bringing a tort claim for a botched sterilisation, but tort law is not sufficiently developed.

CHAPTER 6

STRENGTHS AND LIMITATIONS OF THE LAWS AS PERTAINING TO WOMEN: MEDICAL TERMINATION OF PREGNANCY (MTP) LAW

Prabha K.

Dealing with the law relating to women's reproductive rights, one quickly realises that orders, rules and regulations passed by the Government under obscure statutes can sometimes be more significant than directly related statutes themselves. Acknowledging this difficulty nevertheless, we outline some legislations that have a direct bearing on the rights of women.

The legislative framework on abortion in India can be divided into the specific **Medical Termination of Pregnancy Act, 1971** (hereinafter called the MTP Act) and the more general **Indian Penal Code, 1860**. The Indian Penal Code contains five provisions including two that criminalise foeticide and infanticide. The basic thrust of these provisions is to ensure that an abortion cannot be performed unless in an emergency to save the life of the woman. The punishments for violating this vary according to whether the woman consented to the abortion or not. The passing of the MTP Act in 1971 therefore materially changed the IPC provisions though only in an indirect fashion.

There are essentially five models governing legislative frameworks on abortions the world over. These are :

1. There are no legal regulations of abortion such as in Canada Abortion can be performed on demand.
2. Abortion is permitted on social grounds.
3. Abortion is permitted on medical grounds.
4. Abortion is permitted on socio - medical grounds.
5. Abortion is an offence except where it is performed to save the life of the woman.

It is clear that India had earlier adopted model five whereas the **MTP Act of 1971** would fall under model four. Abortion can be performed on socio - medical grounds that include:

1. Risk of life or grave injury to the physical or mental health of the woman.
2. Risk to the child.
3. Rape.
4. Failure of contraceptive.

Even then, certain requirements that would have otherwise be required under the law (such as the need for the opinions of two registered medical practitioners or that it be performed in a prescribed place or that it be performed between 12 and 20 weeks or after 20 weeks if it is to save the life of the woman) can be dispensed with in order to save the life of the woman. A good part of the critique of the law lies in the manner in which it was passed. The

government had always maintained that the MTP Act was to promote women's freedom and enhance their reproductive health rights. However, it is interesting to note that the Act was at no point of time, an initiative on the part of the public. It was solely a central government proposal drafted by the Department of Family Planning and inspired by the Ford Foundation in view of the increasing number of illegal abortions (estimated to be around 4 million annually) that threatened Indian women's safety.

The MTP Act itself can be characterised as a "supply" law that tries to affect birth control in contrast to a "demand" law that aims at satisfying the basic needs of men and women in the nature of a social security legislation. The MTP Act tends to pay lip-service to the rights of women. For example, in the Statement of Objects and Reasons to the 1971 Act, the legislature expressed alarm at the large number of unsafe abortions being carried out in India. At the same time, the government did not provide the medical facilities essential for women to realise their right to a safe abortion. Thus even in 1974 when it was thought that the implementation of the Act would require 20,000 extra beds in hospitals all over the country, the government had done little in this direction either at the PHC, district or state levels. Also, there was no financial outlay by the Center for the implementation of the Act. As a result, state governments did not possess sufficient funds to implement the Act. For example, the state of Tamil Nadu, after a failed attempt at obtaining funding from the Central Government to improve its medical facilities had to dip ironically enough, into central family planning funds to achieve its purpose.

Further, the lack of accountability of the medical profession under the MTP Act reflects the state's true interest in population control rather than its concern for women's health. For example, medical practitioners under the Act are allowed unfettered discretion in their decision in arriving at their decision to abort. There are no guidelines that prevent doctors from being influenced by the family of the woman in rendering an opinion to abort solely on the basis of the sex of the foetus. Also, the "good faith" clause under section 8 provides doctors immunity from liability and makes it all the more difficult for women to initiate action against negligent doctors. Thus the MTP Act is no improvement from the weak enforcement machineries under the state Medical Council legislations or general tort law. Also, faced with the non - availability of effective, safe and affordable contraceptives, women often resort to abortion as a means of birth control. In this scenario, doctors advise women to have sterilisation performed to make birth control more convenient. Thus, they only reinforce the interests of the state in population control.

Rules and regulations framed under the MTP Act by both the central government (under section 6) and state government (under section 7) respectively seem to affect women most at the grass-roots level. Surprisingly enough, there is a good deal of discrepancy between the provisions of the Act and these rules and regulations. For example, violations of rules are penalised under the law whereas violations of the regulations are not thus penalised. Also, under section 2(d) of the MTP act, only registered medical practitioners can perform abortions. Rule 4 framed under the Act mandates certain qualifications for the same. On the other hand, Rule 5(1) requires such a medical practitioner to possess a certificate in addition to being registered under the Act as well as being qualified under the rules. Rule 5(2) further provides that a doctor not having such a Certificate is prohibited from performing an abortion in spite of his/her being qualified adequately. Thus, violating rule 5(2) does not necessarily mean that

one is violating section 2(d) and Rule 4. This would mean that section 3 of the act which requires that abortion be performed in accordance with the rules framed under the Act, is violated. Another such example would be where under section 3(2) (i) abortion be performed only if there is grave mental and physical danger to the woman by not performing the same. Rule 13 however, requires medical practitioners to certify only injury and not grave injury in forms G and H to ensure compliance with the conditions stipulated under the law.

In the period between 1980 and 1993, there appears to be only one case decided under the relevant provisions of the **Indian Penal Code, 1860**. The case, Dr. Asha Rawal v. Basant Lal 1985 Cr.L.J. 1026 (Delhi) was decided 14 years after the passage of the MTP act. In this case, the woman who had undergone the abortion, Tripta Sharma sought to prosecute her father, brothers and Dr. Asha Rawal of the Marie Stopes Society Clinic. She accused her relatives of causing hurt, wrongful confinement and criminal intimidation and the medical practitioner of having committed offenses under sections 313, 315 and 3126 read with section 34 of the IPC. The Delhi High Court, in effect, exonerated Dr. Asha Rawal and Tripta Sharma's male relatives based primarily on the reasoning that Marie Stopes Clinic could not possibly have any interest in terminating the pregnancy of a woman against her wishes and that since it seemed that Tripta Sharma was unmarried, she would have had an abiding interest in having the abortion performed. Thus, the medical practitioner may have done Tripta Sharma a favour by performing the abortion to save her and her family from disrepute. The Court thus seems to ignore the fact that medical centres like Marie Stopes do have agendas of population control (The Society was in this case affiliated with Population Services). The decision seems to send out the message that one cannot expect any accountability from the medical profession and that access to the legal system to realise one's reproductive health rights is determined by a woman's marital status.

WOMEN AND AIDS

The AIDS pandemic creates various complications for women's reproductive health rights. For example, an HIV positive woman could well be denied her right to have a child though the chances that the virus will be transmitted to the foetus are 30 per cent. Sterilisation for women who are HIV positive has been suggested. Also, it is reported that it is the official policy of two Rhode Island clinics to perform abortions on women who are HIV positive. At the same time, HIV positive women who are desirous of having an abortion are discriminated against in terms of their access to health services on account of their HIV status. In a culture such as India where motherhood is socially valued, women who are HIV positive are in a serious dilemma. They must either bear a child and risk exposing their children to HIV and have people know their HIV status and discriminate against them or not have children and be criticised for that decision.

MISCELLANEOUS LEGISLATIONS:

Amendments to social welfare legislations such as the **Maternity Benefit Act, 1961** in the context of the New Economic Policy and with a view to population control impact severely on women's rights to bear children. The amendments being proposed are that no benefits be made available after a woman's second child and that they be allowed after a woman undergoes

tubectomy or abortion. The other legislative proposal is that no person with more than two children will be allowed to contest elections to the central as well as state legislatures. This is a matter of alarm especially in the context of efforts aiming at political decentralisation.

The Drugs and Cosmetics Act, 1940 covers contraceptives under its definition of a drug. **The Drug and Medical Remedies Acts (Objectionable Advertising) Act, 1954** prohibits any person from taking part in the publication of any advertisement referring to a drug for the procurement of miscarriage in women or the prevention of conception in women.

Other related areas of law include **Contract Law**, **Tort Law**, **The Sale of Goods Act, 1930**, **The Consumer Protection Act, 1985**, Drug Price Control Orders and Poison and Pharmacy Laws.

CHAPTER 7

STRENGTHS AND LIMITATIONS OF THE LAWS AS PERTAINING TO WOMEN: AMNIOCENTESIS AND OTHER LAWS

Veera Rastogi

Amniocentesis is defined as the primary prenatal diagnostic screening technique used for sex determination. It is the technique that the Maharashtra Act addresses and the one that most people commonly think of in terms of sex determination techniques.

The Maharashtra Act was the first Act passed on this issue. Some basic facts on amniocentesis and the horrific situation that is created in terms of sex determination are mentioned below.

In 1901, the sex ratio of men to women in India was 1,000 to 972. Ninety years later, after the advent of amniocentesis in 1991, this ratio has dropped to 1,000 to 929. The number of the drop in the ratio of men to women is almost 50. Between 1970 and '74, 79,000 female foetuses were aborted after amniocentesis due to sex selection according to a survey by Shobha Saxena. Another survey by Shobha Saxena in 1993 based on interviews with 86 pregnant women and doctors of various centres that performed amniocentesis revealed that almost 99 per cent of the women who underwent amniocentesis did so for sex selection with the intent of aborting the baby if it was a girl child. Eighty per cent of those subjects knew that amniocentesis for this purpose was not legal, but felt that it was justified because they did not want a girl child.

Women's organisations protested and the Maharashtra legislature responded in 1988 with the Maharashtra Act. The preamble of that Act states clearly that the Act serves the purpose of regulating the use of these prenatal tests, amniocentesis in particular. It has not referred to any other test and is designed to prevent the misuse of this technique for the purpose of sex determination. So it does not ban or prohibit the use of this test. It is only regulatory and regulates the use of this test.

There are various conditions for the eligibility of this test. The Act clearly states that amniocentesis should only be used to detect abnormalities that are listed in the preamble of the Act which are basically sex linked disorders, **genetic** abnormalities and congenital diseases. It specifically prohibits the use of this Act for the purpose of sex determination.

There are a few other prohibitions contained in this Act. One is against the advertisement of these tests by clinics. So, centres offering this facility cannot advertise that they do so. And, there can be no familial pressure, although this is difficult to enforce. The Act prohibits a woman to undergo this test for reasons of familial pressure. Pressure exerted by the family cannot be legally used as a reason to undergo the test.

There is an enforcement machinery set up under the Act. The State Government of Maharashtra is to appoint a vigilance committee consisting of people from different fields such as the medical profession and women's groups, etc. And, Section 14 outlines the functions of this committee.

Section 21 of the **Maharashtra Act** is interesting and thankfully has not been adopted into the Central Act. It states that, 'Other than the vigilance committee set up by the State Government, no other person may move the courts to take notice of any contraventions of this Act'. That is, nobody can really move the enforcement machinery of this Act other than this Vigilance Committee. This is obviously a large problem in terms of accessibility of the layperson to the enforcement of this law.

Section 19 of the Act goes into punishments. The Act includes a rebuttable presumption similar to the one that is in the Central Act, which presumes that the woman was compelled to undergo this amniocentesis test. If family members are convicted of compelling her to undergo this test, she also may be fined Rs.50 under the Maharashtra Act for undergoing this test. So, there is still a penalty for women undergoing this test but presumptions exist that she was compelled to undergo it. There are critiques of the Maharashtra Act. Many of these have been taken into consideration by the Central Government after informing the Central Ordinance.

Firstly, the Maharashtra Act addresses only amniocentesis which is only one of the many available sex determination techniques. So this Act does not regulate the use of any of the other techniques apart from amniocentesis. Under the Central Act, all techniques of sex determination are regulated.

The second critique of the Maharashtra Act is that one of the conditions for eligibility for amniocentesis is a history of two or more abortions in the woman, whereas the Central Act specifies two or more spontaneous abortions. Now, the difference here is a technical but an important one. In the medical community, it is believed that spontaneous abortions are indicators of a malformed foetus. So, if a woman has had a spontaneous abortion, as opposed to an induced abortion, then it could often be an indicator that her foetus was suffering from congenital abnormalities. Hence, if she has had two or more of such spontaneous abortions, she may have a medical tendency to conceive malformed foetuses. In her case, the amniocentesis test may be medically valid.

The Maharashtra Act requires two or more abortions, the type of abortion not specified, to allow amniocentesis. Hence, under this act, a woman who has had two or more induced abortions based on sex selection reasons is allowed to undergo amniocentesis . So, it is recommended that the accent in the Maharashtra Act should be on the word 'spontaneous' in front of abortions.

The Maharashtra Act should require documented evidence of the woman's claim of spontaneous abortions in the past and also reasons for any induced abortions that she has undergone. This is in order to regulate the use of amniocentesis for sex determination purposes.

Clinics should undertake not to disclose the sex of the foetus because the Act allows for amniocentesis only in medically acceptable cases. But, if the clinic performs amniocentesis for

one of these medically acceptable reasons but discloses the sex of the foetus, it still enables the couple to make the decision to have an abortion based on the sex of the foetus. So, to make this law effective, the clinic should undertake not to reveal the sex of the foetus.

Section 21 allows the implementing bodies of this Act to refuse to disclose their records to the public on the grounds of public interest. So, if someone wanted to enforce this Act they may not be able to get the information needed on the records from these implementing bodies. This causes problems for enforcement and makes the law inaccessible.

Amniocentesis is normally performed in the second trimester, often the sixteenth week of pregnancy and the MTP Act allows for abortions until 20 weeks of pregnancy. So once again, the MTP Act provisions facilitate the use of amniocentesis for sex selective purposes. So, it is recommended that the MTP Act be amended to allow abortions only until fifteen weeks, so that abortion cannot be used for sex selective purposes.

Then, there is a **Disabilities Bill**. For a person with disabilities, equal opportunity protection of rights and participation Bill of 1995 exists. This would probably protect mentally handicapped people against abortions based on eugenic reasons. Some questions were raised about the provision in the MTP which allows abortion based on mental retardation and physical abnormalities and this Bill would probably offer protection against abortion on these grounds. We do not have access to the provisions of that Bill.

Finally, there is one point that needs to be thought about and discussed. It is the fact that in criminalising sex selective abortions, which is what the Maharashtra Act and the Central Act have done, a burden has been imposed on women. From the women's perspective, a woman who conceives a female foetus and finds out that it is a female is forced to have the child if she is not entitled nor eligible to have an amniocentesis and a sex selection abortion subsequently and it becomes exceedingly difficult for her as there is a preference for male children in Indian society. If she is not allowed to undergo sex selection abortion, she will keep having female children in a row in the hope of getting a male child. Pressure is mounted on her to keep having children until she produces a boy and this could create an extra burden on her and her family situation. Do we want to forbid this practice or do we want to consider other factors as well?

Discussions

Q: I want to know the relationship between the Maharashtra Law and the Central Law.

R: The Central Law would supersede the Maharashtra Law since it is a Central Act and people of all the states have to obey that law. Of the critiques of Maharashtra Act, only some have been incorporated into the Central Act.

Q: You had said that the MTP Act has to be amended to 15 weeks as opposed to 20 weeks. Then, the matter of how both the amniocentesis and the Prenatal Diagnostic Act limit the choice arises.

R: There are different categories and different people are placed in different situations. So, the needs of certain sections like marginalised women (prostituted women) or women with special needs (women with HIV) should be looked into. Avoiding all the statistics regarding women and HIV, there is a pressing need to pay special attention to this whole problem.

There are a number of problems that women with HIV face. The main issue is whether they are coerced into having abortions or not producing children at all once they are discovered to be HIV positive. So, they have certain special needs. The one that is common to all HIV positive people is that they cannot be deprived of medical treatment by hospitals, doctors and health care workers.

The other point to be deliberated more on is regarding contraception and HIV. Usage of certain kinds of contraceptives, like the injectable contraceptives, increases the susceptibility to contract HIV.

Now, on to the legal aspect of HIV and AIDS. There is a law that applies to both men and women in terms of HIV/AIDS, but its impact is different. Till now the government, in terms of policy, or the law has adopted a largely proscriptive model of law and is trying to criminalise certain kinds of behaviour with mandatory testing and isolation. We know that this country is protesting against the **AIDS Prevention Bill of 1989**. In the absence of any anti-discrimination law, or any law relating to testing, the constitution should be adhered to. The only limitation is that, it is enforceable if fundamental rights are violated and is enforceable only against state bodies.

Attention is being drawn to a recent case of 1989. It is a Labour Law case where principles of natural justice were held to be integral to Article 21 and were enforceable against a private employer as well. Now, the court did not elaborate on that but if stretched further, a lot of private people could be made accountable for their actions. The only law in India actually relating to AIDS is the **Goa Public Health Act**. **Section 53 (I) Clause (vii) of the Act (it is a 1985 Act, amended in 1985)** allows the government the discretion to isolate people with HIV and AIDS. The consequences of the Lucy D'Souza case are well known. The lawyers were too scared to even refer it to or go on an appeal to the Supreme Court because of the sheer ignorance that the High Court displayed in relation to HIV issues.

There are a host of other laws which could be used against people with HIV and AIDS. These are the **Municipal Corporations Law**, **Public Health Law** and an ancient law called the **Epidemic Diseases Act of 1897**. The basic feature in most of these legislations was in response to epidemics like cholera and malaria, so it is totally outdated in terms of HIV/AIDS. But it could easily be amended like the Goa Public Health Act to discriminate against people with HIV and AIDS.

In relation to refusal to treat people with HIV and AIDS, attention is drawn to a Supreme Court decision in 1989. That was the Padman and Kataria's Case, where the Supreme Court categorically stated that Government hospitals could not refuse treatment to patients who needed that medical treatment to preserve their lives. There are other laws like the prison laws. There is no law directly on HIV and AIDS. There are a number of other laws and regulations, under which, people with HIV and AIDS could be discriminated against.

Regarding testing blood for HIV under the **Drugs and Cosmetics Act**, there are amendment rules of 1989. It was a notification issued by the Ministry of Health and Family Welfare. It provides for cancellation and suspension of the licenses of blood banks. Therefore probably it could be used in relation to HIV/AIDS. Another interesting area is that of contraceptives.

Over the past decade, contraceptive research has been in full force and the majority of the contraceptives being developed and promoted are for use by women and not by men. So, one recommendation is that more attention needs to be given to the development of contraceptives for men so that they also assume sexual responsibility. Another alarming point about contraceptives and research is the experimentation on poor Southern women. Recent contraceptive developments have been of the long acting nature. Once given, they prevent conception for an extended period of time and they are provider controlled. So, these are unlike the pill or condoms where women and men can control their use from day to day. Norplant, for example, must be surgically inserted and removed. There is an injectable steroid contraceptive. There are also anti-fertility vaccines, nasal sprays and other methods which are in the early stages of development.

The bottom line for legal purposes and ethical concerns is that many Northern countries have rejected Norplant, DEPO Provera and other contraceptives on grounds of being unsafe or because of lack of information on side-effects and after effects. But the Indian Council of Medical Research, with the support of the World Health Organisation, has been conducting trials on 'poor and often illiterate volunteers.' The trials are being conducted through monitoring centres, so there is no information on the misuse of these contraceptive trials. The ICMR in mid 1980s conducted the Phase IV trials for NET-N, the injectable contraceptive. Phase IV trials are supposed to be conducted only after the first round of Phase III trials on human beings have been successfully completed.

The surprising fact is that the ICMR went on to conduct these Phase IV trials even after results showed that, in Phase III trials, as much as 70 per cent of women found NET-N unsuitable to their contraceptive needs due to side-effects, after-effects, etc. Some of the side-effects of NET-N range from minor headaches to major ones such as the possibility of cancer or congenital abnormalities to the foetus which is exposed to NET-N while in the uterus.

The ICMR has also offered these contraceptives through family planning clinics along with other accepted forms of contraception like the pill. So, it gives the misleading impression that NET-N has been accepted worldwide or is as acceptable as the pill in terms of a form of contraception. This is misleading, because it has been banned in many countries and not licensed in many others. The ICMR has also conveniently done away with the usual requirement of written informed consent with respect to the NET-N trials and this violates the **Helsinki Declaration**, which provides for some basic ethical standards to be followed in medical treatment and experimentation.

Regarding informed consent, the basic content of informed consent is that the patient or the user of contraceptives should have full knowledge of the circumstances, so that they can exercise their choices. Their consent should not be under misrepresentations. So, in the medical context, the patient deserves a fair explanation of procedures to be followed, including all side-effects and after-effects, if any. The benefits of the procedure should be described to them so

that they can weigh the benefits of the procedure against the risks. And, there should be an understanding that the patients can withdraw their consent at any time during treatment or experimentation. The health care provider should also offer to answer any questions that the patients may have.

In terms of law, US law in this matter is quite unsettled. British law says that the rights of the patient to information are to be determined based on whether a reputable body of medical opinion would have considered certain risks to be disclosed. So, the court will determine the amount of information given to a patient based on the opinion of a medical body.

In Canada, the standard is slightly more favourable to the patient. Here, the patient's right to know is based on what a reasonable person in the same circumstances as the patient would have wanted or needed to know. So, in legal terms, it is called a mixed objective and subjective standard. Here, there is a certain amount of outside opinion as to what the patient should have known but that is taken into account along with circumstances particular to that patient. For example, if a patient is in a certain line of work and needs to know the effects of a certain procedure on his eyesight or dexterity, then those concerns will be relevant in that patient's circumstances. This is a law with regard to medical treatment and not necessarily experimentation. All the literature available on the standards of informed consent can be extended to cover the experimentation situations.

The Helsinki Declaration gives basic ethical standards for bio-medical research and experimentation. There are certain important provisions which say that the interests of the subject of experimentation are paramount. The benefits of any proposed procedure or experimentation should be proportionate to the risks. In other words, the benefits should be greater than the risks in the procedure. And the patient or the subject of experimentation should be fully informed of all aspects of the procedure at all times. In India, there is no statute or case law on informed consent. There are ICMR policy statements on ethical considerations. There are also various constitutional provisions which can be mobilised in protection of the right to informed consent in the context of experimentation.

The NET-N technology led to a Supreme Court petition which has been filed in 1986 by three women's groups, namely, Shre Shakti Sanghatana, Chingari and Saheli. This Petition was filed against the government, the ICMR and the Drugs Controller of India as well as the State of Andhra Pradesh. The Petition revolved around the hazards of NET-N, the lack of informed consent involved in the trials, inadequate health facilities associated with the provisions of this contraceptive and also the potential for abuse during the trials. The Petition demanded a Stay Order on further trials involving NET-N and also called for complete information on the trials. They also asked the court to appoint an expert team to investigate the issues involved in the trials of NET-N.

In December 1990, the three groups filed an additional petition asking for a stay order on trials of other contraceptives such as NORPLANT, anti-fertility vaccine, vaginal ring and nasal spray. This Petition asked for all available documents regarding these trials as they had done for the NET-N Petition earlier. They also demanded compensation for women who suffered adverse health effects following the trials of these technologies. Further, they asked for exemplary damages for women who, though they may have not suffered adverse health effects,

had participated in trials without informed consent. Finally, there was a request to the court to direct the government to frame rules regarding the conduct of these types of trials.

The Petition was filed under **Article 32 of the Constitution** which grants a remedy for violation of fundamental rights. The fundamental rights involved came under **Article 14** which is the quality provision of the Constitution. It says that there should be no discrimination. **Article 15 (3)** provides for special provisions for women and children. **Article 19 (1A)** is the freedom of expression clause which is interpreted to include the right to acquire information so that women have the right to information in order to make informed choices on the contraceptive use and their participation in trials, etc. **Article 21** which is the right to life and liberty is being used in the sense that these trials have basically constituted invasions of women's personal liberty in terms of lack of informed consent. They have also invaded the dignity of these women as they have been treated basically as guinea pigs of experimentation.

Finally, there is a right to information which also can be mobilised. This falls under **Article 19 (1A)** of the Constitution and can be restricted by **Article 19 (2)** of the Constitution on the grounds of public order, decency or immorality among others. **Article 19 (1)** could be mobilised to protect the right to information of these women. There is an **Official Secrets Act of 1923** which restricts public right to information and where wrongful communications in respect of classified information is an offence. The **Officials Secrets Act** potentially could be used against the acquiring of information under **Article 19**. Certain sections of the **Indian Evidence Act**, namely, 123, 124, 125 and 162, protect the State from disclosure of documents and communications, which are privileged and the publication of which would be prejudicial to the public interest.

So, there are various provisions which could stand as obstacles to the right of information under Section 19 of the Constitution. But, the Constitutional provisions need to be looked into to protect women's rights in this contraceptive and experimentation area.

Part III

STRATEGIES AND IMPLEMENTATION OF WOMEN'S HEALTH AND RIGHTS IN INDIA : GOVERNMENT AND FIELD PERCEPTIONS OF THE PROBLEMS

CHAPTER 8

INITIATIVES, STRATEGIES, RESPONSES AND RECOMMENDATIONS OF THE GOVERNMENT

Sanjay Kaul

In response to some of the issues that have been raised, we will touch upon some initiatives which the Government, or at least the Government of Karnataka has taken in the implementation of health and family programmes. The aim of this paper is to cover a whole range of grassroots problems faced by both service providers as well as beneficiaries. I will, therefore, not go into broad national issues like,

- should the country have any demographic goals?
- should we speak of sustainable development in terms of numbers?
- should we begin thinking in terms of over consumption and issues of that kind?

Attitudinal change

2. There has been a definite change in attitude within the government on issues relating to women's health, in large part due to the work done by various women's groups. This change is evident in the fact that even when issues of conventional family welfare and fertility control as an object of government policy are being discussed, there is widespread acceptance that Government should offer a wider choice of both short and long term contraceptive methods. Hitherto, population policies have revolved around terminal methods of control. Both the Government of India and most State Governments now consciously accept - while talking of fertility control or family welfare or demographic goals - that a choice must be offered to the community, to the women in particular, of a wide range of contraceptive methods. This will enable them to make an informed choice.

3. The government has, for sometime now, recognised that safe pregnancy and safe delivery services are important areas but these have been neglected. The CSSM programme funded by the World Bank has revolved around training of dais, supply of iron pills etc., but beyond these it has not gone further. This is an area where much more need to be done. Infrastructural support has to be improved.

Unwanted pregnancies

4. The prevention and management of unwanted pregnancies is an area which has gained importance in recent times. We are fortunate that there has not been much opposition, either in the press or in any other circle, on providing MTP services in India. The legal framework now exists though it has not been translated into providing these services at the Primary Health Centres. The major problem is more the nervousness felt by good doctors about officially showing MTPs, and not so much the question of minimal facilities or providing the infrastructure for MTP services. This is evident by the fact that most of the doctors admit to having done a large number of MTPs for a private consideration, but do not put it on record as they feel

that the government may not encourage or support such action. The Government of India has recently funded a family welfare Survey for all States, the findings of which is just being published. One of its findings is that in Karnataka one out of five pregnancies is unwanted. Of these, how many were aborted by going to quacks or people who were not equipped to carry out MTPs, is not really known. The estimate of 1 in 10 abortions being done illegally is perhaps not far off the mark. So, the government has accepted it as a Policy that we must provide and have an institutionalised mechanism of providing MTP services on a wide scale. In addition, for providing safe delivery services, the existing interventions with the CSM and the ICDS programme of providing nutritional assistance to pregnant, nursing and lactating mothers are already being implemented, with all the attendant weaknesses and inadequacies.

Male participation

5. A widely accepted fact of Indian society is the dominant role of the males in deciding the size of the family. But the involvement of the male in the family welfare programme has been minimal. Minimal in terms of interaction between the couples, in taking the mother to the Primary Health Centre or in making the choice from the available contraceptives. The sterilisations in the '60s and early '70s comprised 50 - 70 per cent of male vasectomies but the present record in Karnataka is a dismal 400 odd vasectomies out of 4 lakh sterilisations performed annually. In the next three or four years there may be a shift to other spacing methods though, at present, sterilisation remains a major contraceptive method. Male participation and male involvement has to be stepped up, not only for terminal methods, but for other methods as well. The use of condoms as a family planning method has been absolutely nil despite the fact that lakhs of contraceptives are shown to be distributed. The importance of condoms is increasing since there is a linkage between the use of condoms and HIV prevention.

Reproductive Health

6. The Karnataka Government has begun to talk about reproductive health and strengthening infrastructure support for women's health. Most State Governments are doing the same. The government documents now talk about the life-cycle approach and reproductive health. The Family Welfare Department of Government of India has circulated the draft outlines of a reproductive health project to State Governments for future funding by the World Bank which, in principle,has said that there will be an IPP-10 which would be focused exclusively on reproductive health. Karnataka is one of the States which is presently implementing IPP - 9. I am personally in favour of having reproductive health as a subcomponent in IPP - 9 itself instead of waiting and negotiating a fresh document with the World Bank.

7. A document containing a whole range of women's health issues is being prepared and is being shown to the Health Department in Government of India for funding by the World Bank in the Health Systems project presently under negotiation. The specific intervention measures suggested from this workshop will be incorporated in the document. A breakthrough has been achieved with the Department of Health also accepting the intervention about women's health. Otherwise, the whole gamut of maternal health issues falls into the domain of the Department of Family Welfare. There was one advantage in this for State Governments because the Department of Family Welfare has traditionally been better funded than the Department of Health which has been concentrating on areas such as medical education, the CGHS Scheme,

Indian Systems of Medicine, malaria control, leprosy control, T.B. control, blindness control and other health programmes. So, there is no exclusive programme for women's health. Unlike the Government of India, the Government of Karnataka has been resisting attempts to break up the department to Department of Health and Department of Family Welfare because Family Welfare has been unfortunately separated on the ground that it needs a more focused drive.

Gender Sensitization

8. The other major intervention that the government is proposing to introduce is the area of gender sensitisation. In principle, it has been agreed that all training modules for ANMs and medical officers will have a component of gender sensitisation. A suitable person with medical knowledge is being identified to indicate how gender as an issue could be incorporated in training modules. We have a large amount of funding for training and our existing training modules have been fairly sound technically, but they do not focus on gender issues.

9. The broader issue of providing nutrition and education without gender differentiation at the community family level e.g., less food to the girl child - is also an area where Government is keen to take the initiative and translate this policy into concrete interventions. There are certain other interventions required such as introducing screening and treatment of cervical and breast cancers. We have prepared a comprehensive document identifying interventions which can be taken up immediately and those that can be taken up subsequently. But interventions such as cancer prevention require a great deal of preparatory work and perhaps can be taken up at a later stage.

STD Control

10. The Government has also recognised the need for enhancing interventions in respect of the entire range of issues relating to prevention, screening, management and treatment of RTIs and STDs. Unfortunately, STD control has become the exclusive domain of NACO (National Aids Control Organisation), STD control is linked with HIV surveillance and control. However, STD prevention strategies need to go beyond setting up STD/HIV sentinel surveillance centres. It will also require proper orientation of ANMs and health workers. The health structure must also improve its access, specially to women, for treatment of RTIs and STDs. This will require not only strengthened infrastructure, but also breaking the inhibitions of women in approaching health centres for treatment of RTIs/STDs. In Karnataka, our strategy paper for control of HIV/AIDS, which has become accepted Government strategy, is a little different from the NACO strategy.In terms of funding, the NACO Aids control programme has been more focused on blood safety and less on promoting safe sexual behaviour for HIV prevention. Our strategy's main focus is on safe sex.

11. Other areas that the Government is thinking of translating into interventions, relates to adolescent health, and addressing problems relating to post-reproductive period, with the older set of women as the target group. Then comes the entire issue of prevention and treatment of infertility. Women who do not want to bear a child, presently get left out from the entire spectrum of the health care system.

SC/ST Women

12. We have introduced a special programme to improve the access of scheduled caste and tribe women into the health care system.This will be achieved by a team going to the sub-centre and screening SC/ST women in annual/bi-annual checkups. These health teams will compulsorily have a lady medical officer (LMO).The idea of tackling women's health without LMOs in the indian society is just meaningless. The Government recognises that there are many biological differences between women and men so that there is a need for maintaining separate health cards for men and women. They require different types of screening and medical examination. Where Government LMOs are not available the services of a private LMO will be drafted; she need not be a gynaecologist.

High Risk Pregnancies

13. Another important area is dealing with obstetric emergencies and their treatment which is linked with the issue of access to women's health in our hospital system. Authentic NSS data based on hospital surveys show that in the hospital system, for every thousand men, there are eight hundred women. This number could go down to six hundred if the inpatients admitted for tubectomy are removed. The difficulty lies in the fact that the health system will require a great deal of strengthening to deal with high risk pregnancies. In a workshop where doctors were also involved, it was recognised that the PHC would not be the appropriate place to treat such cases. Even community health centres would not be able to provide treatment services to deal with high risk pregnancies and caesarian sections. We are trying to provide these services in the taluka hospitals. In Karnataka, there are 175 of these. All high risk pregnancies will be screened and the couple will have to be motivated to come to the taluka hospital for the delivery of their child. Another difficulty is that though the State has over 200 gynaecologists, a large number of them are in Victoria Hospital, Vani Vilas and in various district hospitals. The Government tried during the general transfers to pull out not only the gynaecologists but a large number of other specialists as well from bigger hospitals and post them to taluka hospitals. Out of a cadre of 4000 doctors, 400 specialists have been pulled in the general transfers from the PHC/major hospitals and posted in specialist posts at the taluka level. There is also the difficulty that when lady medical officers are posted to PHCs or taluka hospitals, they resist or refuse due to domestic reasons. There is a major difficulty in getting a lady medical officer to work even in taluka hospitals, let alone work at the Primary Health Centres. In this background, without special strengthening efforts emergency obstetric care at the taluka hospital level will be difficult. The need for a proper referral system is now recognised, because the infrastructure needed to tackle high risk pregnancies are not available anywhere in between the taluka hospitals and the large hospitals. The PHC functions like a first aid outpost, not as a health care centre; it was never designed to function as one. One PHC has about 6-7 ANMs who are in geographically given areas. There is no staff nurse around the clock for a patient to be kept there and treated; therefore to expect the primary health care system to provide any curative health care is difficult to visualise. Hence our hospital system has to be strengthened in order to service the referral cases.

NGO collaboration

14. The issue of collaborating with NGOs to deal with specific health issues is another matter engaging Government attention It is not known as to what extent their successes can be made

use of to develop replicable structures though their experience could be made use of. Government structures are huge but slow. It may not be feasible to translate the successful micro experiments into huge Government structures. However, there are areas and sectors for example, remote tribal areas within every State which prove difficult to be accessed by the Government and hence the Government structure does not work. So, the Government has agreed that in certain remote inaccessible tribal areas, it would experiment with entirely handing over a PHC to an NGO. Dr. Sudarshan is working with tribals like the Soligas with excellent results. He has volunteered to take one PHC in Mysore district, where he is working, and run it. His conditions are that he will not be bound by any Government guidelines regarding staffing and recruitment, but he is prepared to implement all the national health programmes and that he will bring in his health workers. As this is going to be a limited exercise in any case, such experiments could be tried out in remote areas like backward districts of Gulbarga or Bellary. A survey has been commissioned in Karnataka to collate and compile information on NGOs working in the area of health and other activities district-wise. For this a consultancy agency has been appointed and it is using some of the faculty of the Administrative Staff College of India.

" Targets "

15. Another matter I have not touched upon is "targets." Only one district, Mandya has been taken up for completely giving up sterilisation targets. The present practice in the State is the camp approach, wherein, a group of doctors are taken from point to point, and patients are collected and operations performed.One way of avoiding the camp approach is to have a system where good services are available at the PHC level. Another way is not to have any target as we have done for Mandya. This concept has to be expanded to other districts. In districts where the health infrastructure is good and ANMs are in place, the performance is excellent.In the "target free" district, performance indicators have been listed out and will be monitored, through well thought out reporting formats. Identifying suitable performance indicators for the ANMs constitutes the first challenge.

Budgets

16. In terms of budgets, World Bank funding accounts for about five per cent of Karnataka's health budget. But with that limited five per cent funding, they seem to have more visibility and influence on Government policies. It is disturbing that though the aid is of a marginal nature, it has wide ramifications. Such World Bank funding with conditions attached to it becomes an arena of concern. Even the ICDS programme of the Government of India is assisted by the World Bank. The World Bank came initially with preconceived notions of what is good for ICDS, which is a universal programme. Their premise was that universal programmes are not cost effective. Hence a nutritional parameter was proposed, which meant that every month the baby was to be weighed and if the baby crosses grade II, it was pushed out of the anganwadi. The World Bank was persuaded to get out of this selectivity if they wanted to fund ICDS. Practical problems exist everywhere in introducing selectivity. The Government of Andhra Pradesh introduced the system of Green Cards with the idea of issuing the cards to targeted people below the poverty line who were to be provided with supplementary grains. But, on introduction of the scheme, more cards were distributed than the number of households in Andhra Pradesh. Andhra Pradesh introduced a criterion of Rs.6,000 as the income ceiling; only families below this income level were to get the Rs.2 per Kg. food card, but household

cards for an estimated 85 lakh households were issued which meant that some households would have received two cards. Then the Government went into the exercise of weeding out those cards.

17. What I would like to say is that the difficulty with any funding agency will exist unless it appreciates Government structures and how they work. The only way to deal with them, particularly the World Bank, is to be firm. The views of NGOs on these issues is important as the Government of India and the NGOs can work together to ensure that the funding agencies for these programmes do not lose touch with reality. In priority areas, if there is common consensus among women's groups and other NGOs than in Government interventions, the components that are important to everybody is retained. The health budgets from within internal Government sources are going to remain very marginal for sometime to come. Hence it is important to user properly foreign funding.

18. Each change in the State Government brings about changes in the important areas of concern as reflected in the wishes of the elected legislators. So, health and education will not get the enhanced allocations that they need. For example, if there are power projects requiring large investments, health budgets will not be enhanced. Hence, for the expanded range of interventions and large investments, external funding will be needed. Pressures will have to be put to retain health priorities as well as to broaden the scope of the existing projects such as the IPP projects. CSSM covers all the districts for programmes like safe motherhood and child survival. It is not need-based. The Government has now decided that all new interventions would only be in six districts of Karnataka, namely, Bidar, Raichur, Gulbarga, Bellary, Bijapur and Dharwar all of which have very poor health indicators. The **Suraksha** programme of the Government is also confined to these six districts and is a child health scheme. The need for this scheme has been recognised by the legislators as well. The Legislator's Subject Committee, an institution which scrutinises budgets, has been persuaded to approve all the new interventions. Apart from negotiating with the World Bank, the Government is negotiating a similar health systems project with a German funding Agency. The project costing 30 million Deutsche Marks (about Rs. 60 crores) will exclusively cover four districts of the Gulbarga division.

19. In the State Planning Board, another important issue, that of integration of structures, came for discussion. The chairperson of the sub-group on Social Development suggested the integration of all social sectors and implementation of programmes together. But the Government faced several difficulties. One was that even within the Health Department, there are vertical programmes and hence, diversion of funds from one area to another is impossible. The government is listing out the various schemes and is exploring the possibility of putting them under a common umbrella, a common budget, so that they can be need-based and have a little flexibility. When ICDS was supposed to be expanded (in Rajiv Gandhi's time), the concept was to have in every district, a district Woman and Child Development Agency and integrate the ICDS functionary with the ANM to be headed by an Indian Administrative Service officer. But,the proposal never took off. Even the nodal department in the Government of India which would control this entire umbrella was not decided upon.

20. NGO groups can assist the Government to see whether more flexibility can be introduced in our funding programmes. What should be looked into is whether there is scope for reappropriation in our budgetary allocations, and if there is scope for avoiding money lapse and if there can be closer monitoring at the PHC level.

Drugs

21. There also is the problem of improper utilisation of budgets which is disturbing. Karnataka's budget is Rs.50,000 per Primary Health Centre. It's one of the highest in the country. But without a proper list of drugs, wrong and unnecessary drugs were stocked in the PHCs. Now, there is a list of about 50 essential drugs for the PHCs which has been drawn up. Earlier, we never had norms on what drugs should go to the PHC. So there was the practice of the private drug firms, trying to influence the lower level District functionaries for placing of orders. If one went to a typical PHC, one would find, for instance, a whole host of ointments, mainly skin ointments. Some of you may have worked in PHCs, or even a non-medical person would wonder why you have tubes and tubes of ointments, or penicillin stacked from shelf to shelf or rolls and rolls of bandages flooded in the Stores room. Now that we have finalised a list of drugs, there should be some improvement.

Private Practice

22. Another issue that needs attention is private practice by Government doctors. A Cabinet Sub-Committee is getting to this issue but it is not an easy problem to tackle. The tertiary institutions which pay substantial salaries to their consultants pose another kind of problem. In the event of introducing a ban on private practice, the Government would pay a non - practising allowance of Rs.1000 which compares very poorly with the salary structure of private tertiary institutions. In Karnataka, private practice is not illegal. The doctor is permitted to do private practice at home, after duty hours; he is also permitted to declare one nursing home where he can do surgeries, after hospital hours.The modalities of the order of banning private practice are being worked out. But this kind of banning has not worked out well. In some states where private practice was banned, they are thinking of reintroducing it. Our rural health care system is not only poor in quality, but also understaffed. We also have the other spectrum of hospitals like Bowring, Victoria where we have excellent surgeons, who have a roaring practice and getting about Rs.1 lakh per month.They attend to very technical sophisticated surgeries - dialysis nephology, cardiac bypasses,etc. Government salaries alone cannot attract doctors who can do these kinds of surgeries; and if private practice is banned, the patients may be left to the mercy of the super specialities hospitals.

Maternity allowance

23. The Government of Karnataka has an important scheme where every landless agricultural woman labourer is entitled to Rs.300, two months prior to the delivery date and one month after that, as compensation for loss of agricultural wages. But, the disturbing thing about this scheme is that even this amount does not reach the beneficiaries in many cases. To get that Rs.300 per month for three months, the woman is expected to sign several forms and go to three different levels. The government is trying to simplify the process by various methods including giving the responsibility to the Gram Panchayat so that the system can become more easy to operate and become transparent.

Quality of care

24. Another important issue is the concept of quality of care, especially post operative care. Quite often in sterilisation operations, the woman is herded into a jeep and forgotten about after the operation. The Government is addressing this issue. While the government has invested in a large amount of infrastructure,it does not provide for maintenance of the equipment or the building. Given the constraint of resources, my personal view is that for sometime the level of infrastructure that is built should be frozen, and no expansions should be allowed. For the duration of the last three plans, the Family Welfare Department has been obsessed with two things. One was with sterilisation targets, the second (where all the money went) was with the total number of sub-centres and total number of Primary Health Centres that should be sanctioned. Along with that came the concomitant sanction of buildings, infrastructure, equipment and staff. And, yet, most PHCs lack water. Hence, it is impossible to do even minor surgical procedures and even conduct deliveries. So, the Government is trying to now invest in providing water supply. We have now provided for expenditure under "Plan" to procure surgical instruments and for maintenance of certain facilities.We have been able to replace a large number of much needed medical equipment in the tertiary sector i.e., in our medical institutions and attached hospitals. Our total medical education plan budget incidentally is Rs.35 crores of which Rs.5 crores was provided to replace equipment is a very large chunk. The Government has allocated, for the first time, about Rs. One crore in our Plan budget for repairs and maintenances of PHCs and sub-centres this year.

25. The International Institute for Population Studies situated in Bombay has been commissioned by the Government of India to do a survey across the country on the provision of the whole range of family welfare services. Different institutions were made nodal agencies in the country for conducting the surveys. The Institute of Social and Economic Change was the nodal institution for Karnataka. The survey document has now been released which makes many important observations on the quality of Family Welfare services being provided in the State.

Questions and Responses

Q : We would like to have some details regarding the programme components of the World bank funded IPP - 8, 9, etc.in terms of the basic components of the programme, thrust and their other policies. Are they under Health and Family services or with Bangalore City Corporation?

R : The IPPs are with both. Two IPP projects, IPP-8 and IPP-9 are being implemented. The IPP-8 is a project covering some major cities including Bangalore and covering all the urban slums of Bangalore city. The IPP-8 project is being implemented by the Bangalore City Corporation under the overall guidance of the Health and Family Welfare department. IPP - 9 is a statewise project; this is a conventional family welfare and MCH project, which is a follow-up on two other IPP projects that we had in Karnataka, IPP-1 and IPP-3. The IPPs are numbered by the World Bank, based on when they were launched in a chronological manner. IPP-10, to be started in the future is supposed to be a reproductive health project. IPP-6 and 7 are the ones which are being currently implemented in Andhra. IPP-6 is also covered by Madhya Pradesh. IPP-9 is in Assam, Rajasthan and Karnataka. Broadly, the contents of the IPP projects have concentrated on hardware support like the construction of

building, equipment and they provide some software support in terms of training. As for the time period, every World Bank project is designed for five to six years spilling over into an extra year making it a seven year programme. Each World Bank project has two cost estimate components - a base cost and a fairly sizable contingency provision of 35 per cent. Flexibility in utilising the funds available without cutting down any of the components would be a boon to the State. In both IPP-8 AND IPP-9 there is funding for innovative approaches through voluntary organisations.

Q : My basic question is on the relationship between the Central Government and the State Government in the area of population policy. What is the differential jurisdiction of the funding authorities in terms of policy making?

R : The States are entitled to have their own initiatives in Population Policy. But since most of the health programmes are centrally sponsored schemes with 100 per cent funding, most State Governments share the view that for introducing any strategic changes, the initiatives must come from the Centre. The State Governments feel comfortable to talk about changes in policy if the Centre gives a lead. Hence, it is important, for women's groups, to strongly articulate their views at the Centre, as, in some way it does get translated into Policy statements. These Policy statements get reflected into State Government budgets and the State Government Policy document. The states are entitled to have policies different from those of the Centre in respect of State funded schemes but most States have a set of policies consistent with Central Government policies. Some small schemes funded at the State level reflect the state's priorities, but they are not always in the right direction.

Q : Even though centrally funded, the implementation of the schemes is at the state level. But there still seems to be a grey area of this relationship between the two. Implementing the schemes and reaching the targets is within the State's jurisdiction. If the state budget is Rs.4 crores for family planning, is it for allocation to the state by the Central Government? What is the State's contribution, and what is the Central Government's contribution to Karnataka on population for family planning?

R : The contribution of the Central government for family welfare is about Rs.70 crores. So the total budget is Rs.74 crores.

Q : Does that Rs.70 crore also include World Bank funding or is it a separate component?

R : Our total revenue expenditure in health and family welfare is Rs.226 crores. Our capital outlay is Rs.31 crores. Our total planned expenditure on health is Rs.226 + Rs.31 crores for the total planned expenditure. The non-plan expenditure is Rs.342 crores. Large portions of the non-plan expenditure are salary expenditure and recurrent salary expenditure which is borne by the State. Central funding is basically plan funding and Non-plan funding is State funding. The budget is for health and family Welfare together. The document includes IPPs and CSSM as well.

Q : How is the patient treated? Is the patient harassed by being told that she cannot be handled there and asked to go to some other hospital where the service that she has come for is available? The delivery of services is a crucial issue. How does the government plan to handle

it ? Can the excess money that is expected to come into IPP-8 be used to renovate the existing PHCs and maternity hospitals? Is there any way of stopping the corrupt practices that go on in the maternity hospitals? What is the future of the women who have been diagnosed as having cancer after the screening for breast and cervical cancers? Will they be referred to private expensive hospitals or are they going to be handed over to NGOs? Is it not better to separate reproductive health from the family welfare, particularly with regard to screening of cervical cancer? If reproductive health care has to be offered, it should be made available even to women who are over the age of 45. Cancer detection camps have no follow-up. As far as the HIV problem is concerned, something has to be done about blood banks.

R : In regard to cancer treatment the government policy is that the Kidwai Memorial Institute of Oncology (KMIO) will take up all cases identified as suspected cancer including treatment and follow-up. With regard to blood safety, NACO strategies have already been focusing on this. Infected blood accounts for about 15 per cent of HIV infections. At the same time the promotion of safe sex which accounts for 85 per cent of HIV infections cannot be neglected. All NACO funded blood banks will adhere to the stringent screening methods as NACO is the principal funding agency for AIDS prevention. Today, there is a law which requires all blood to be screened before it is put into blood banks. But there is no monitoring system. So, it is estimated that about 40-45 per cent of the blood is used before it is screened. The Government policy does not neglect blood safety, but it is also focusing on safe sex. Regarding the issue of IPP and quality of care, the Government is looking up to women's groups for specific suggestions and ideas from the grassroot level to improve quality of care. Corruption can be reduced only by introducing greater transparency in procedures and decentralised systems. The solution is twofold, first, by providing greater hardware support by equipping our hospitals, by providing instruments and clinical skills to the doctors and second, by introducing more simplified and transparent procedures.

Q : Why does the government not think about the mini sub-centres in each village staffed by a local trained village woman and treat some simple and common diseases, first aid and delivery? Then, there will not be a recurrence of cases like the one who was sent home after a delivery despite a profuse haemorrhage. She died at home. Can you train the local village women?

R : There is a very ambitious programme beginning this year, of training our traditional birth attendants (dais). The targets are about 5,000 this year, the modules are in place. For sometime, people have to rely on the dai. So, two interventions are being introduced, one is to give her disposal delivery kits and the second is, the training of dais. In addition, there are as many as 9000 sub-centres, as against 5,500 Gram Panchayats. So, we have one ANM for every 3,000 population which is a fairly large number.

Q : Is it possible to provide kits for the 50 dais of the Mahila Samakhya who are doing traditional deliveries?

R : Certainly. Under the **Suraksha** programme, delivery kits have been ordered . Please ask your project officer to get in touch with the government if he has any difficulty.

Q : The programme officers say that they give the kits to only trained dais who have undergone government training, not the others

R : We would like only the trained dais to do deliveries, the emphasis being on training. If NGO groups, like the Mahila Samakhya, are willing to train them, the government will certainly provide the kits. If a list of all the dais who are being trained by various agencies is given to us, we can provide the kits. Since the kits have to be prepared under sterile conditions the government does not want to give that responsibility to any other agency. The kits are not expensive. They just cost Rs.6.

Q : Who is accountable for the Programming and the implementation of the Dais training programme? Who is accountable for the high risk cases? Are the PHCs and gynaecologists of the Centre responsible?

R : The dais should not take on any high risk pregnancies. After some screening they should be sent to a properly equipped community hospital. High risk pregnancies cannot be tackled at the PHC level. On the anvil is a programme to equip our hospitals with specialists and equipment and also introduce clinical skills management programmes.

Q : The dais very badly need your assurance that they get their dues as, being the lowest link, they do not have any spokesperson to raise their voices.

R : Yes, I assure them that if any specific cases are pointed out the dues will be immediately released. The procedure can be streamlined with the help of suggestions from women's groups.

Q : The government has a massive programme of constructing houses for the poor. Is it possible to give one house to the women in each village, so that we can think in terms of safe delivery.

R : In addition to housing, the Government has proposed other interventions for women. There are broadly three issues. The first are land based issues. The theoretical premise is that women have had no control over property and hence have no control over their bodies and lives. In this context, two or three interventions have been accepted by the Government, in principle. One is the issue of " **Saguvali** " chits, that is, land grant pattas. Under this scheme, the unauthorised Government land is regularised under Government schemes and the chits will be given in the name of the woman. The second scheme is the issue of house sites. It is proposed that in all such cases, the patta titles will be in the joint names of the husband and wife. Further,it has been suggested that all surplus land allottees will get land in the name of women. With the amendment to the **Hindu Succession Act** coming into force in July 1994, daughters are allowed to have co parcenary rights. And now, the Department of Women and Child Development is pushing to get women a share in the property of their husbands after they get married. All income and property that accrues to the household is a joint effort of both the spouses, even if the wife is a housewife or stays at home.

In the area of education and literacy the focus is on girl enrolment, schooling and their attendance in school. There is a major programme by the Primary Education Department, called DPEP - District Primary Education Programme - which puts a lot of emphasis on this. The Department is also doing a gender scrutiny of all school text books. Legal literacy for women is another focus area in all total literacy campaigns. In rural areas there are now as

many as 34,000 Gram Panchayat women constituting 42.6 per cent of the 80,000 odd Gram Panchayat persons elected in Karnataka. A comprehensive training programme to make their participation effective has been worked out by the Woman and Child Department. There is another important development that needs to be taken note of: That the Women and Child department itself need not have several schemes for women, because that department's budget is small and does not get proper funding. But each department must have a women's component, something like the components for scheduled castes and scheduled tribes. The Women and Child department is now insisting that there must be specific schemes for women in every department, so that the focus remains on women. Most departments have committed to having the women's component from this year. However, to tackle issue of women and children in the health sector, specific intervention, rather than mere budget provision should be demanded.

Q : I have been working with the urban health programme for a long time and urban health has been completely neglected. Hence a social auditing on health must be done.

Secondly, the women in crisis, for example the dowry cases, end up in Victoria hospital or Bowring. The conditions are atrocious and the women are not treated properly. The police intervention is not done properly. The issues of violence and the hospital system must be looked into properly.

The third point is, after involving the NGOs and the brains of the women's groups in the planning stages of various schemes, the government ignores them. Hence, a public grievances cell should be established wherein issues relating to health and others will be heard, so that your programme will be very well implemented when the suggestions of the public are incorporated into the government structure.

R : Your concerns will be conveyed to the Project authorities. There are two useful components, one is the concept of 'she clubs' or women's groups in the IPP-8 project. The second is the concept of a local village health functionary for every slum, who would act as the link between the worker, the slum and the City Corporation. These link workers would not be hired, fired or recruited by Government at all; this would be decided on by the 'she clubs.'

CHAPTER 9 [a]

REPRODUCTIVE RIGHTS: WOMEN AGAINST THE POLITICS OF COERCION

Bhargavi Nagaraja

Human civilisation, having traversed through the trials and tribulations of history, is now at the brink of new uncertainties that cloud its fate and obscure the future.

Historically for women, it has been a never-ending saga of pain and violence, of subordination and oppression, of economic deprivation, of gender inequality, of suppression and oppression, of struggles against the onslaught of multiple patriarchies, in the family, in individual relationships and in wider society. The gains of the women's movement, so bitterly fought and precariously won, are still threatened by structures, systems and institutions of society wherein the dominant, male - ordered ideology dictates the assured legitimacy of handing over the control of women's minds and bodies to men, the family and the state.

The women's movement, beginning with the first wave of feminism, principally fought for women's equal rights to the fruits of production through equal opportunities at work, training, equal pay, participation in decision-making and political processes. Decades later, the women's movement is now being called upon to join debate on reproductive rights, an issue raised at the International Conference on Population and Development (ICPD) at Cairo in 1995. Any such debate would be meaningless, inconclusive and isolated unless matched with guarantees by society, judiciary and the State safeguarding the interests and health of its female population. What is a normal biological function of the female should not, even symbolically, become a battleground for patriarchal domination, gender inequality or gender hierarchies whether generated by society or state.

Through the years of history, these patriarchies and others clamour to control reproduction and have worked feverishly to recast the womb according to the needs and the dominant ideologies of the day. Fascists, socialists, dictators, monarchs, theocrats, and even democrats have all harnessed women's reproductive functions to State policies in the past, and continue to do so now. Hitler ordained medals of honour for German, non-jewish matrons who gave birth to many children. The Victorian era saw large families in Britain and her colonies. In the Philippines- a predominantly Catholic society - the average family has 4-5 children. Singapore which adopted a rigorous and repressive population control policy, saw a drastic reduction of population and now desperately seeks to increase its numbers by offering incentives to couples to marry and have children early. The backlash to China's One-Child norm is well-known, with the unchecked spate of female infanticide, thanks to the "son preference." Thus the State has played a major albeit invisible role in reproduction patterns either directly or indirectly. Policies have been used to clamp down on fertility, to regulate and liberate it. This strong bag of muscle in a woman's body called the uterus or the womb has been subject to a variety of role plays, cast, uncast and recast by policies and patriarchies.

Science and Technology have often been the pliant tool in the control of reproductive rights, as part of the State Policy. Fertility controls using hormones, research into anti-fertility drugs that have not been totally proven as safe and technological limitations are being targeted at women using them as guinea pigs. The ideologies that subtly direct the agenda for research, are linked closely to the dominant ideology of the day and the dominant politics of the time but rooted in the basic attitude of population control.

Population control appears to gain worldwide acceptance and Neo-Malthusianism may well become the prevailing doctrine of the day with the rallying cry that unchecked population growth is the source of all poverty, disease and environmental degradation - a faith rooted in a system that reduces the complexity and variety of human suffering to numbers, statistical analysis and economic variants. This approach to national and global crises appears to be the common consensus among political leaders everywhere, so much so that it is taken for granted, barely questioned and any serious criticism is quickly dismissed as heretical or total ignorance. The inclusion of this doctrine by even progressive and powerful environmental and development groups is no accident either.

The obsession with numbers has drastic consequences for women, whose bodies offer a strategic site for intervention by population control technologies. Many of these have side effects both severe and irreversible - which may or may not be passed on to women as user information. It is the politics of control at State level that targets women and not men with these technologies.

In the words of Lynnette J. Dumble, Senior Research Fellow, University of Melbourne, medical elements from the broader scientific framework including pharmacology, endocrinology, obstetrics, gynaecology and others relating in one way or another to reproductive biology have been extensively tapped to develop the medical paradigm that has underpinned population control politics for the last 40 years. Delivered by Family Planning programmes, the paradigm's dominant features are contraceptive drugs, and to a less extent - sterilisation and abortion. For women whose fertility is blamed for global poverty and famine, environmental degradation and declining public health standards, they become more than medical interventions, acquiring sinister overtones.

The same contraceptive research has met with little success in regulating male fertility, with the lone exception of sterilisation through vasectomy. Loss of libido is voiced as a major complaint against male fertility formulations and hormonal contraceptives. Consequently women have been compelled to bear the burden of fertility regulation despite the inconveniences and health risks that are inherent in the technologies used. It is again ironical that these technologies which are accessible to women in developed countries are wielded like the proverbial stick to control population in developing countries and thus become powerful instruments of control and coercion.

Most women in developing countries, going in for Family Planning, are denied full information of the nature, scope and risks of the technology. Depo-Provera, the first of its kind of long-acting contraceptives, did not get the official license till 1992 in the U.S A and until 1994 in Australia - mainly due to its association with canine mammary malignancy. But by this time, Depo-Provera had been already prescribed (off-label) for 20,000 North American and 3,000 Australian women. The exposure of ethnically disadvantaged and often disabled women, black

and Hispanic in the USA and Aborigine and immigrants in Australia, to long-acting hormonal contraception has prioritised cost-effective delivery ahead of individual women's health in a travesty of the racial disruption of their sisters' fertility in developing countries.

According to the World Health Organisation's (WHO) Special Programme on Research, Development and Research Training in Human Reproduction (WHO/HRP), Depo-Provera is currently used by 9 million women in more than 90 countries. But population agencies underplay Depo-Provera's effect on body weight as "slight in some women" and totally avoid mentioning its other proven and published side effects including lethargy, malaise, mood changes, fluid retention, migraine and hypertension which disrupt women's everyday lives. Other serious concerns which lurk in the shadows are the drug's potential to increase women's risk of breast and cervical cancer, and premature osteoporosis by diminishing the bone density of the users. Further, it is claimed that over a period of 5 years, Depo-Provera contraception reduces bone density of the lumbar spine and neck to levels that are intermediate between those of premenopausal and postmenopausal women.

Norplant, an even longer-acting contraceptive consists of 6 silicone capsules which are inserted under the skin of a woman's upper arm. To date its mechanism in preventing pregnancy is not clearly understood. It prevents ovulation in some women, thickens the cervical mucus and in others it blocks the preparation of a uterine lining that is implantation-friendly. Figures from Finland where Norplant is manufactured show that its prescription and use in this progressive country are influenced by social inequities similar to Depo-Provera's prevalence - Norplant users are younger, have 3 times less advanced education, are mostly single, and twice as likely to be unemployed than users of oral contraceptives.

WHO reports that Norplant is now available in some 20 countries, has over 2 million users and enjoys increased acceptance across the world. In contrast, health experts and activists report that Norplant induces even more debilitating effects than Depo-Provera, including menstrual irregularity, mild to severe headache, weight variance, loss of libido, skin and hair problems, nausea and depression. That the need for establishing efficient and painless procedures for the removal of Norplant capsules was overlooked is somehow very difficult to explain. Just as with silicone breast implants, the Norplant capsules resist attempts to physically extract them from a woman who can no longer bear their effects. It is now proven that silicone is harmful, and after contact with body tissues, it promotes encapsulating inflammatory fibrous tissue reactions that can promote anchoring tissue growth around and into Norplant's silicone containers. There are also growing reports of babies born to women after Norplant contraception with limb and chromosomal defects.

Sterilisation has its own problems. The United Nations found in 1989 that men sterilised through vasectomy constitute just 10 per cent of those practising birth control of any kind (5 per cent in developed countries versus 12 per cent in developing countries). The stark reality is that more women than men have undergone tubal ligation (33 per cent in developing countries). This is despite vasectomy being free of complications, and offering a 95 per cent rate of successful reversibility which does not apply to women. The widespread propaganda of sterilisation, especially tubectomy by governments in developing countries has ensured that more women undergo sterilisation than men, and this is especially so in the poorest families where women lack awareness and a working knowledge of the medical and clinical aspects of contraception and fertility regulation. Indeed they are shackled by societal and familial prejudices

that acknowledge them only when they establish their fertility beyond doubt by giving birth to a number of male children. Generations of women have suffered from the administrations of poor surgical skills resulting in injuries, callousness of health care staff, almost non-existent post-operative care, apart from sepsis, endometriosis, menstrual disruption, backache etc.

Despite initial trials showing that the antiprogesterone RU 486 (mifepristone) failed to induce complete abortion in 20-35 per cent of women, population managers continue to invest in chemical abortion. Even after "improvements" by adding a second chemical, one in every 20 women has had to suffer from an ongoing or incompletely terminated pregnancy. Apart from taking 7-14 days' time for abortion to occur, pain, nausea, diarrhoea and haemorrhage are side effects of RU 486. Further contrary to its promise to provide a private, take-home solution to an unwanted pregnancy, at least 3 medical consultations are mandatory. WHO which sponsored RU 486 trials in developed and developing countries, recently extended the drug's applications from early to late first trimester abortion to post-coital or morning-after contraception. The effects of this practice are yet unknown. The politics of abortion are well-matched by the politics of propagating RU 486 - both disruptive rather than regulating women's fertility. Further the legitimisation of medical paradigms through loud endorsements by WHO has only strengthened the developing countries who see their women as expendable commodities. Racist and eugenic at the least, the medical paradigm also ensures that the concentration of the cream of opportunities for health care, educational privileges etc., are in the hands of a few. This is overtly maintained affirming the patriarchal causes of poverty without challenging them in any way.

Anti-fertility sera have been labelled as vaccines by the multinational, multi-billion dollar pharmaceutical industry. Does that suggest that fertility is a disease? Who has the right to propagate such sexist biases? Should not agencies such as WHO with their mantle of assumed neutrality play a more pro-women, pro-health role, instead of their present functioning as self-appointed custodians of the bodies and wombs of millions of impoverished women in the world, colluding with governments and managers of population control programmes? Should women's rights to information not be ensured now? Should women not be the prime movers against the policies of coercion and control of their fertility? Can States assure such rights to their female citizens as a matter of course, delinking female health aspects from the wider politics of production and poverty? Governments are eager to regulate women's fertility but are virtually silent on the feminisation of poverty in their countries - especially in developing societies.

The Indian development model has fallen into the trap of population control concentrating heavily on fertility regulation for women, and fails to create social and economic conditions that favour fertility decline. Without ensuring the survival of infants in the country, the government has no right to use coercive strategies to control reproduction of women. Further a government that fails to recognise women's health needs before and beyond the labour room, can derive no legitimacy or logic in using women's fertility to control their social and economic status, especially as it continues to deny women rights to development through manipulating opportunities for women's advancement, neglecting conditions of women's employment etc.

States are not beyond coercing women to undergo sterilisation to qualify for coverage under development programmes. Thus what advances were made by WiD (Women in Development) - sensitive programmes in the direction of women's literacy, training and entrepreneurship,

have been nullified by insensitive demands for targets. So we find that the promised gains have been snatched away by inequities in the dominant ideology of development, still denying women's rights to land and other resources, as also their right to a life of productivity, purpose and personhood, over and above reproduction. Without strengthening women's economic base for productivity, efforts for their "empowerment" remain bureaucratic exercises confined to paper.

Women's access and equal rights to resources have been a point of contention to patriarchies in the State, society and family. Changes cannot come about on all these fronts unless attitudes also change from top to bottom, and development demands no less.

The disparities become even more pronounced as the language of professional conference delegates becomes more theoretical, departing from the actualities of social and cultural compulsions on women to procreate and the State's rigid controls on the womb. Hierarchies in familial and social relations stem from not only gender but also differences of ethnicity and class. Sexual relations are fraught with so many inequalities that decision-making on neutral grounds about fertility and reproduction goes straight out of the window. This provides a golden opportunity to policy makers and officialdom to skirt the reality of the situation, although there is no squeamishness in exercising controls on reproduction, fertility regulation, ignoring gender issues and pandering to a male-dominated, male-oriented, unequal power structure in the family and wider society.

From a point of view that is unclouded by power struggles and yearning for peace and humanism, it is not for history, the present or the future to recast the womb, but for women to understand, derive strength and comfort from their epoch-making role as progenitors of the race. But they also need to be wary of attempts to subvert their role by unscrupulous purveyors of power who seek to strengthen themselves by enslaving the minds and wombs of the earth and its women. Development and modernisation are signposts on the road to authority; adjustment and restructuring make up the metaphor of its language, and the motive is total control. But both modernism and economic restructuring skirt the prioritisation of assuring public health services and insist on privatisation as the alternative. With the State preparing to shed its role as service-provider, the question arises as to who will take responsibility now.

Other questionable inequities that go unaddressed are the international trade and labour markets, the rigid centrist controls on development aid, the increasing suffering by the poor, the loss of wages, loss of jobs, the displacement of the poor and the powerless through loss of access to natural resources such as land, water, forest and rights to harvest them as well as the absolute lack of rights and power at the negotiating table. As development becomes more and more controlled and directed by the strictures of structural adjustment and economic restructuring, inequities grow rampant and the polarisation between the haves and the have-nots is sharper than ever before.

Those that design and direct social policy in the coming years will need to keep all this in mind. However, the reproductive rights debate will remain incomplete and inconclusive unless governments and societies realise that over and above the rights at stake, it is the reproductive freedom for women everywhere that is the single most potential issue that can and will affect the future health and well-being of society itself.

CHAPTER 9 [b]

FIELD PERCEPTIONS - DISCUSSION NOTES

INTRODUCTION:

During the consultation a special session was arranged where participants and members of government had a free exchange of experiences, often determining the contours of the problems faced by women today and the directions in which solutions must be sought. We felt it would be useful to structure the discussions somewhat and include them for this issue. Much of the discussion notes will appear anecdotal but in our view they reflect true pictures of the lifeworlds women in India must endure. Some of the experiences related here suggest great and unspeakable violence, degrading not only to those who lived through those realities but to society as a whole that has tolerated such a range of violations - linguistic, material, ideology on the dignity of women. The medical community and the state government services appear in a poor light. What emerges is not just a questionable quality of professional services but an almost pathological cruelty towards the very women whom they are supposed to serve. We are sorry to note that there is an increase of neglect, of directly instrumentalised violence and of the use of coercion and power to subjugate women when they seek information, health care and treatment.

Statistical evidence on maternal and infant mortality must be viewed along with the dehumanising culture, prevalent in health centres run for women primarily but ruled by an inherently patriarchal, anti women form of governance. These first person accounts of life in our institutions and in the public domain call for drastic changes and resistance against the negations described.

The Editors.

1. WOMEN, STD AND HIV/AIDS

1. COUNSELLOR

This counsellor has been involved in direct counselling and predominantly, telephone counselling. She talked about service delivery in government health institutions and the abusive language which government health personnel use on the patients. According to her, this happens in most of the STD departments of government hospitals. She felt that introducing a counsellor in the government VD department who would act as a negotiator and a mediator between the poor women patients and the Head of the Department would be quite successful.

One of the problems that she outlined was the lack of a private area for the examination of female patients. There is an absolute refusal to treat HIV positive women. They have liaised with government authorities to get a private area for women patients in some government hospitals by the use of a curtain or a wooden partition acquired with their own funds. This private area has made the doctors grudgingly accept the fact that the environment needs to be improved. She has also been working on sensitising hospital personnel, particularly the STD Department. For example, 90 per cent of all HIV spreads only through unprotected sexual

intercourse. So, each patient is given a demonstration of the correct way of using a condom by using fingers or a penis model itself. The response has been very positive.

When questioned about the most common issues that she dealt with as a counsellor, she explains that since all the patients have come with STD, it is prudent to tell them why they have the symptoms. The second issue is their ignorance of the correct usage of condoms. They are taught about it by using models. When women infected with STD come, they are asked in a cordial way to bring their partners. The males are convinced to wear the condoms. The women are advised (since 90 - 99 percent of them get the infection from their husbands) not to have sex till the treatment period is over and after that, to always use a condom. The idea is reinforced by insisting on the same with the man as well. The man is told to use the condom even when he goes with other women so that he does not infect his wife. The counsellor articulated that the women are quite powerless in these issues and when they are affected they only cry. Hence, they need to be talked to and guided properly.

2. FIELD WORKER

She expresses the fact that when they give condoms on the field, they often get harassed by rowdies and others, even by policemen. Many women who are in prostitution get caught by the police who say that these women are also soliciting in addition to giving condoms. Then the field worker has to go to the police station and inform them that those women work for SIAAP. The police say that they should stand in one particular area only for ten minutes and give out condoms, after which they should quit the area. The field worker feels that this is not practical as it takes time to reach out to all those women. These women are street workers in Madras and Tamil Nadu area.

These women are informed that while they can solicit clients to make a living, they should protect themselves when they are going out with clients. They are told that they have to use condoms as the AIDS virus is very prevalent today and they might get into trouble.

The field worker narrates an incident of a HIV positive girl who needed a tonsil operation and no doctor was willing to touch or operate on her. Her mother tried to convince the doctors but failed. Accepting the death of her daughter as inevitable, the mother nevertheless felt that it would be better if the daughter were to breathe her last in the comfort of her own home. And she took her home. The doctor asked the mother to bring the girl again after a week. But the girl died at home after one week. This is the condition of patients who come into hospitals today with HIV.

When people from other wards come near the HIV wards, the attendants tell them not to go near the wards, because there are AIDS patients in the wards. Usually four or five youths stand near these wards. When the women inmates come out, they are made fun of and mocked at by these youths. When a woman goes to the teashop to get tea, they announce that she has AIDS, even though she is only HIV positive. The field worker mentioned the case of one of their staff who is HIV positive (she was tested for it in 1986) and the treatment meted out to her.

The field worker narrates an incident where, once when the HIV positive lady was standing on the verandah of the hospital, she was told by the ayah not to stand there as she had AIDS. The ayah would not accept the fact that she would not be affected by the presence of the lady on the verandah. Later, the same ayah entered the HIV ward to watch television. Then, the field worker asked the ayah ironically if she could get AIDS when she watches television with the patients or when she steals their food, milk and eggs. This is the status of the treatment meted out to HIV patients today.

She feels that these women should be trained in some kind of a job, so that when they leave the hospital, they can make a living. Otherwise, life becomes very difficult. For them, even admitting children to school becomes very troublesome. She cites the example of her HIV positive colleague who is abandoned by her husband. When this lady took her son to school for admission, she was asked to produce a certificate saying that her husband had abandoned her. Such technicalities make it very difficult for these women to admit their children to school. Now, her son is at home without getting an education. Despite repeated attempts she could not admit him to school. "Children who are HIV positive are being discarded in dustbins and rubbish dumps. Some kind of a shelter or home should be started for these children. All that the HIV positive people want to do is to survive". Even in families where husbands die of AIDS, the wife suffers. So, all these women should be given training to earn their own livelihood. A hospice can be built for people who are HIV positive. The medical personnel in government hospitals should be sensitised.

The field worker also felt that people were slowly getting over their initial resistance and were coming forward to accept condoms from her. She has also requested the man in charge of the lodge to keep condoms in a plate so that all the people who go in can pick up one and go in. She requested the man not to be tempted to sell them. She says that the women are insisting on the men wearing them even though some men protest that they do not get complete satisfaction with it. She puts emphasis on safe measures by telling people that Tamil Nadu will become "AIDS Nadu". She works mainly with sex workers. She also feels that once the education has reached to the level of SSLC and above, women will not agree to go back to selling vegetables or fruits on the streets, or to construction work or unskilled labour. Hence, more and more women will be drawn into prostitution leading to unprotected sexual relations and possible infection of HIV/AIDS.

She felt that the visual media, by projecting all kinds of attractions through advertisements have increased the need for money. And, because of fast money as well as degrading entertainment no one pays any attention to long term health.

3. ACTIVIST

Some people who have been working with HIV here in Bangalore have had a bad experience during the distribution of condoms. "When a woman is distributing condoms, the police pick her up with the idea that if she has condoms she must be a sex worker and they prey on people that way." Therefore, there are some negative consequences of distributing condoms. The important issues that need to be paid attention to are the rights of people who are HIV positive along with those of their partners. These issues need to be discussed. Should the same standards set by WHO be followed or should our own standards be evolved? Here, in India, the possession of condoms is seen as evidence of being a sex worker.

4. ACTIVIST

When people are arrested the phone number of the organisation is given. So they call from a particular police station, and one of the organisation members goes and releases them. The police are told that they are doing this work for the organisation. The organisation negotiates with the police, gets them released on bail if necessary and bring them back.

5. LAWYER

The problems faced while working for HIV prevention have been brought out very well. It will be a superficial look at the problem if the basis of the law relating to prostitution is not dealt with. A lot of these problems arise because prostitution is criminalised in this country. If the talk is about sex workers being discriminated against, or if a worker is labelled as a sex worker because of the presence of condoms with her and is harassed by the police, it is because the law in our country penalises prostitution.

The social factors that make sex workers more vulnerable contacting to HIV should also be examined. So, the problem has to be dealt with in a comprehensive manner. It is difficult to negotiate with a client as to the use of the condom when the sex workers are totally criminalised, stigmatised, and all laws are against them.

This perspective has to be carried over to the area of reproductive health rights and specialised needs of these marginalised women. Women in prostitution, women with disabilities, women with HIV have a whole set of other issues in addition to reproductive rights which need to be addressed urgently. And directly on the point, Juvenile Justice Act, clearly says that the child of a prostituted woman, is treated as a neglected juvenile and is put right into a government institution. So reproductive rights are not limited only to having children or deciding how to space them at all. It also means that they have a right to be with their children.

It is ethically objectionable that most HIV prevention groups are working with prostituted women without addressing the basic issues of disempowerment. Most of these women do not even perceive HIV/AIDS to be a priority area. The main issue is that they have creches for children. So, either reproductive rights or HIV prevention cannot be looked at without addressing these larger issues. Information regarding HIV/AIDS should be accessible to all.

6. SOCIAL SCIENTIST

It has now become clear that the law is completely inaccessible, and does not deliver justice. Along with self - help groups working on issues like HIV/AIDS, a community of lawyers, scientific experts and others who can deal with other issues are needed. The community of professionals have just not been responsible enough. At one level the victims of this society are being asked to come forward as victims which is bad enough, but are also expected to mobilise, to resist, to struggle and to form institutions of resistance. They are also expected to do all the institution building work. It is just not possible.

The failure has been in the community of professionals who have done nothing. There is a young law reform group in the National Law School, who for the last three years or so, have

been working on various social issues. They are needed to play a supportive role to groups like these. It cannot be expected that initiatives coming from the grassroots should be coordinated entirely at the grassroots level.

There are various factors in the whole issue of resistance today. One is that not enough work on the actual empowerment of women has been done with a focus on HIV/AIDS prevention. So also the issue of civil liberties: That was a question raised by one of the first who fell under the AIDS Prevention Bill and was in prison - Dominic D'Souza. It actually took a victim of this illness to begin a major debate in this country on HIV/AIDS as a human rights issue.

The professional communities, whether they are the medical fraternity, scientific communities, lawyers, etc., are at fault. There are not enough of them who are also serving in public interest centres. There are very few economists who are concerned about these issues as a social justice issues. The tragic failure today is that people in positions of access to knowledge are just not doing enough in terms of actual advocacy work. Grassroots level resistance to this issue has its own limitations.

Their hands need to be strengthened. People need to be constantly vocalising their concern. A large number of actual institutional mechanisms in society are needed to form a national platform. This platform will bring the focus on to these issues, so that those at the grassroots are not constantly vulnerable and exposed to the threat of the state machinery and elite institutions.

7. POLITICAL SCIENTIST

With regard to groups like SIAAP the programme with commercial sex workers is not a target oriented programme and the women are not looked at as targets. The philosophy in their work is that they are looking at the most vulnerable sections in the HIV pandemic. And the whole attitude towards that programme is to protect the women from HIV. It is more to protect the women than to prevent the spread of HIV. So, the approach itself is different.

The next issue is the increase in prostitution. The interaction with various groups across Andhra Pradesh, Orissa, Tamilnadu and Karnataka, groups have definitely brought out the fact that there is an increase in the number of women coming into prostitution in the last three years. The other issue is concerning the various HIV/AIDS awareness programmes including those of the NGOs. All these awareness programmes are targeting women. They are targeting commercial sex workers as being responsible for HIV.

NACO brought out two advertisements. In the first, two men are in a hostel. One is having a good shave and putting on an aftershave, and the other man opens a drawer and sees pictures of a number of women. The first man asks the second what he is doing with all these photographs and the second replies that he is having fun; the friend then asks him whether he had not heard of AIDS. And the freeze is on the photos that are there.

In the second, the focus is on the transmission of HIV through intravenous needles and the needle exchange which the drug users use. There is a whole group of boys and girls sitting and exchanging the needle. It freezes on a girl who is inserting the needle and talks about HIV

again. So, this is going to be a major problem and if things are not set right now, the issue of HIV and its effect on women, especially the commercial sex workers, is going to be unthinkable.

8. SOCIAL WORKER

In terms of HIV/AIDS, it should be made known to people that women get HIV more easily from men than transmit HIV to men. Because of the way the female reproductive tract is built and because the semen stays in the vagina much longer, it is easier for more women to contract STDs from men which often go undetected. It is also because their nutritional status is very low. The chances that a woman will get HIV from a man is much higher than the other way around. But the media always depicts the women as being the reservoir of infection. The attitude is that if prostitution is got rid of, then everything will be fine. This kind of information or these kinds of issues in awareness programmes need to be highlighted if we have to bring a gender sensitivity to the issue.

2. DELIVERY OF SERVICES FOR WOMEN

1. FIELD WORKER

She works in a very remote area with very poor communication facilities and the distance from the hospitals is very great. So, it is very difficult to take people to the hospital when they need treatment.

There was a case of a woman in an advanced stage of pregnancy who was ready to deliver. When she was taken to the local PHC, as she was a very poor woman, the doctor told the field worker to take her to the town of Madhugiri as she could not be treated there in the PHC. The family could not afford a car, so they took her by bus and the child was delivered in the bus. It was very clear that the doctor who referred her to Madhugiri was only interested in getting some money and knowing that she was too poor to pay, sent her away without giving her treatment at the right time.

There was another case where a girl was raped by a wealthy boy, but when he was brought to book and taken to the police station, a wedding ceremony of sorts was held there. The boy was made to tie a bit of turmeric round the neck of the girl which signifies culturally, a marriage ceremony. After that he kept her at home for four months, and then he tried to send her away. The girl was three months pregnant. When she was taken to hospital, he tried to compel her to have an abortion, but the girl refused knowing that it would strengthen her claim on her rights. She refused an abortion consistently.

When the field worker tried to take it up legally, she was told that only if it were a registered marriage (even though there was a photograph of the on-going ceremony), would it be tenable in court. She was told that only a registered certificate of marriage would be valid. So, the police informed her that there was nothing they could do. And, she came to know that the police were bribed Rs.4,000 by the wealthy family of the boy. When several marriage proposals came from Bangalore for the boy, the field worker made sure that the people were informed

about the unjust treatment of the girl by this family and were shown the photograph of the wedding thereby effectively preventing the marriage. This is being done till date.

The family tried their best to threaten the life of the girl. They even tried to kill her, but the women's group was very strong. For over a year, the field workers were with her all the time to give her physical protection so that she would not be murdered. Finally, the boy came to the group and agreed to marry her. The women's group insisted on the marriage being a registered one, but he was willing to undergo only a temple wedding. The women's group did not accept it and finally, after a long struggle, we were able to get them married and the marriage was registered at Madhugiri a month ago.

She hoped that all was well with the couple. She went on to say that when women approach the courts or police stations, even when the men are in the wrong, the police are always bent upon harassing the women. Even the girl mentioned above was scolded and abused verbally in intolerable language, and the police asked her whether she was not aware of what she was getting into. This was the only successful case; there were several others in which the women's groups were not successful. She expressed her doubts about getting justice in the court or at a police station. She appealed to all the women present at the conference to make it possible for women to go and get justice in such places.

The field worker was questioned as to whether they went and gheraoed the doctor when he refused to deliver the baby. She replied that after the baby was born, they went back to the doctor and confronted him by telling him that contrary to what he had told them about the case being a risky one the baby was born in the bus. But, he turned it to his advantage by saying that it actually was a high risk case, but the baby was delivered because of the shaking movement of the bus! The second issue that she raises is the dishonesty that the medical profession practices in not being able to tell a patient the truth.

2. MEDICAL DOCTOR

She also faces problems when HIV positive patients go to her for treatments of various malignancies. She explains that there are no definite guidelines laid down for them. When a patient comes in with HIV positive needing surgery, the amount of investment that is necessary for that patient is very high and so, in most instances, in many institutions the patient is sent back without surgery. They do not like doing invasive tests because the staff protest.

She gives an example of a 19 year old girl who came with chorio carcinoma which is a treatable and curable cancer. The patient claimed that she was raped, subsequently became pregnant and she had an induced abortion. The mother had been deserted, there were two younger children and she was going for some computer training when this whole thing happened. She was HIV positive and had chorio-carcinoma. Even after a departmental discussion and concurring that it was a curable cancer, they were at a loss as to the next course of action.

As the Centre for them was the Bowring Hospital, they wrote a letter to the Bowring Hospital requesting the status of the patient who is HIV positive and also has choriocarcinoma which is a curable cancer. The Bowring Hospital replied back with a note saying that, as far as the HIV status is concerned, they could go ahead with therapy for cancer. Then came the burden of finding the money for it.

As they lack the infrastructure (like gloves, etc) needed to deal with the drawing of blood of or any other invasive procedure on these patients, the patients are identified by marking the case files as 'bio-hazardous'. Under such conditions the staff rebel refusing to take on the responsibility of managing an HIV positive patient and getting infected themselves. This protocol is followed even for Hepatitis B, which is transmitted in a similar manner.

They were fortunate in deciding on a oral kind of therapy for her and the treatment is being followed. But, there are patients who have been refused surgery in various institutions. There is no policy and this has to be developed gradually. She mentioned that the infrastructure for treating these HIV positive patients needs to come in. This is because all the linen that is used for them has to be discarded, the instruments have to be disinfected with hypochlorite solution and many other requirements which are not available right now.

She cites another example of a patient with oral cancer who came for treatment. The patient was anaemic, and was given blood which was HIV infected. The patient became HIV positive and subsequently was not treated. She felt that a policy has to be evolved as there are many instances like this and that the people in the medical profession cannot do much.

3. CORRUPTION IN HEALTH CIRCLES

1. PARTICIPANT

This participant mentions an incident that occurred three years back. A lady, an engineer in the Electricity Board, went to a hospital which is a part of the Medical College in Trivandrum. It was expected of everyone who was admitted in the hospital to pay the doctor at his residence after a lapse of one or two days. As this lady did not pay the doctor, she was not attended to in the labour room even when she got strong labour pains. When she felt that it was time for the baby to be born, she called out to the doctor to take care of her and was told to watch for the head of the baby. Then, he walked away. When the lady shouted loudly the doctor returned and saw the head of the baby. He made the lady get up and walk. On the way she delivered the child and it died. The lady engineer's sister, who was working as a professor in the Calicut Medical College, brought up the case. Within a week, Health Minister ordered an enquiry commission. This resulted in the suspension of three doctors.

In some government hospitals the corruption is so rampant that patients who go for sterilisation end up spending more than Rs.1000 so that they do not have any money when they return home. This corruption that goes on in the hospitals needs to be stopped to strengthen the point of accountability of the hospital staff towards the patients.

4. MALPRACTICES, MEDICAL NEGLIGENCE, ACCOUNTABILITY AND SURVIVAL ISSUES

1. ECONOMIST

She says that her statements are going to be politically incorrect. She feels that the golden state of Kerala is not golden at all when it is looked at from close quarters and from the point of view of the issues of women's rights and women's health.

The second point that she mentions is the role of responsible unionism. Public hospitals are the filthiest places and when the sweeper does not discharge his duties properly, no one can enforce discipline on them. She feels that the time has come to ask relevant questions regarding these issues. Accountability and the kind of suffering that people go through in the public institutions due to lack of this accountability are the issues that should be raised with the labour organisations. Their behaviour with women, the way they treat women and their corruptive practice are issues that should be addressed. Unless people like ward boys and ayahs are made accountable, endless corrupt practices cannot be stopped.

2. FIELD WORKER

The field worker narrates an incident which happened in a PHC in her area in Andhra Pradesh. A pregnant woman who was going to the PHC for regular checkups went there for her delivery. She was sent home a short time after she delivered a baby boy. When she went home, she got labour pains again and delivered again. Both the babies died due to lack of medical care. The doctor who attended on her got himself transferred to another place almost overnight by using his influence with the MLA and ministers. The field worker's queries about the rights of such people and asks how they can get their rights.

3. MEDICAL DOCTOR

This participant talks about the events that occur in private hospitals from her own experience as a junior doctor 15 - 16 years ago. If the consultant doctor has not arrived to conduct the delivery, the head of the baby that is being born is pushed inside by the nurses. Junior doctors were not allowed to conduct these deliveries as the cases belong to the outside consultants. The head is pushed in and kept waiting till the consultant arrives from outside the hospital. And even the middle class women, who are usually strong, end up with prolapses because of pressure after about two deliveries of this kind. This is total medical negligence. No one talks about it because they lose the fees that they get for conducting normal deliveries. They also conduct caesarian sections even when it is not necessary. This is proved by instances where the doctor delays the procedure to attend a party and the baby is born normally after two hours ! Malpractice suits need to be filed.

4. JOURNALIST

She talks about the practices of some of the best known gynaecologists in the city working both in government and private hospitals who make sure that patients have only a caesarian delivery even if they are likely to deliver normally!

The second issue is about the MTP cases that come to the general hospital. She talks of one of the government hospitals in Bangalore where the women, who want MTP performed on them, are asked to come in the evenings and check into the hospital.The MTPs are performed early in the morning. The male doctors are believed to be indulging in sexual assault and harassment and say "since the patients are going to be cleaned up the next day, it is alright to have a fling in the night!" And the most difficult part and the crux of the problem here is that the cases that go for MTP are not registered according to the rules. So, it can never be proved that they came and were made to stay for a night. When there are no grounds at all, how can the law work for these women?

5. LAWYER

The Consumer Protection Act does not apply to the PHCs and the government service centres. It is a decision that has been rendered by the body created under the Consumer Protection Act. The women still have access to the general civil law system, as the undeveloped ' **Tort** law of principle' which upholds the reasonable person standard, which, in turn, usually includes the reasonable man standard and the reasonable professional standard. Hence, there is scope for public interest litigation for groups in India who want to legally push these issues further.

As regards the private front, there is an infinite scope for public interest litigation and for the legal movement. If there are problems with doctors in private settings, the Consumer Protection Act does provide some coverage and in fact, medical negligence coverage.

There is a need to bring cases under that Act and the Indian Medical Association is trying to reverse that decision, because the doctors do not want to be held culpable even in private settings. But there is still scope to bring more lawsuits against private sector doctors like the doctors who work at PHCs and who have their own private practices. And, within the scope of their private practice, there should be creative legal practice that holds them culpable for their medical negligence in that private practice.

There are possibilities to expand the legal framework. Regarding MTPs, according to recent records only six lakh MTPs are recorded while it is estimated that 70 lakh induced MTPs have been done in this country. As a lot of paperwork is involved, they are not recorded. According to the rules and regulations, the doctors who perform the MTPs are expected to fill a form. This, apparently, involves a lot of paperwork and hence they all avoid it. The MTPs are often therefore performed without any registration.As all this information is based on one or two studies the information is very incomplete and inadequate. Though the MTPs that are performed in hospitals need registration, hospital number etc., the records are inadequate because the rules and regulations are not followed. This aspect needs to be looked into.

Abortion and MTPs fall within the criminal law. If it is not under the MTP, it comes within the purview of the penal code which is a criminal act. Accountability and enforcement of the MTP become a big question when a doctor fails to report a MTP.

6. COMMUNITY WORKER

She shares an incident from her experience. A patient who started to develop labour pains was referred to a government hospital as the patient hailed from a low socio-economic status. When the patient was admitted the duty doctor, a gynaecologist, examined her and stated that the delivery would be normal and left the hospital after fifteen minutes. But the staff nurse who examined the patient opined that the delivery would not be normal and that the patient would need to undergo a caesarean section. She also advised the patient that, as the necessary instruments and suture materials were not available in the hospital, she had better go to the private nursing home, which is run by the same doctor.

As the participant did not know what to do, she referred the patient back to the government hospital believing that the hospital had the complete infrastructure and the facilities required

for a caesarian section. She stated that as she knew very well that the patient would have a normal delivery she wrote a reference mentioning the economic condition of the patient and requested the hospital staff to ensure that the patient had a safe confinement. She was concerned about maternal mortality and morbidity in her mind. A man came up to her that and informed her that the doctor and staff nurse have a secret understanding. The staff nurse continued to insist on the patient getting discharged from the government hospital and getting admitted in the nursing home. While the argument continued, the woman delivered normally. The delivery was conducted by the second staff nurse who came on duty. Quoting this incident, the participant admitted that in such circumstances, she is at a loss as to the course of action that she should pursue. She mentioned that the patients are being compelled to get admitted in private nursing homes.

7. ACTIVIST

The real solution for this accountability of the professionals is to start a movement against these types of professionals. This is happening in every village. So, how can it be controlled? There should be a strategy to pin the doctor wherever he goes. The movement should be gradually built against these types of professionals.

8. FIELD WORKER

She said that in the sheds that house the Primary Health Centres, goats and cows are found instead of people. The situation of the poorest Dalits is deplorable in those areas as the doctors never bother to look at them. An ANM is supposed to conduct the deliveries but she refuses to conduct deliveries in the nights. And will not come to the colonies where the Dalits live if she is a higher caste woman.

In another instance a woman died as the doctors rushed instead to the house of one MLA to conduct a delivery. "For every delivery, at least 12 coffees have to be supplied. A lot of paper work which requires at least one hour needs to be done. The staff assures the people that the patient will be looked after well but they will keep chatting while the patient is in great pain! Even in the emergency ward 12 coffees is a must for 4 people. The other things demanded are two soaps and a towel for every delivery even after which the new born baby is not cleaned properly. Such is the health system in our country." The field worker is at a loss as to what should be done in such circumstances.

9. FIELD WORKER

She talks of the whole process of how an urban poor women's organisation gave them a health education covering all aspects like health awareness, bringing down the death rate of children, mortality rate of children, family planning, sanitation and water facilities. She feels that it is impossible to deal with health alone It has to be looked into in all its totality which involves such factors as conditions of work, sanitation and housing She has motivated people who already had 4 to 8 children, before she started the family education programme to limit their families Today, women are not afraid of questioning anything because that is how they become more knowledgable.

10. ACTIVIST

"Women are logical, they question and do things. It is possible for women to stand on their own feet. Awareness programmes of all kinds are necessary. In Women's Voice, there are 11 communities doing extensive health work on all fronts. There are 54 units covering all aspects of health issues like HIV/AIDS, cancer, alcoholism and its effect on women etc. All these are covered through various cultural programmes that will be educate women.

Women's Voice consist of 54 registered units. The number of members in each unit differs from 20 members to 800. Every unit is being managed by women committees called 'Women's Voice Unit' after which there we have council members and executive members.

Every month there is a meeting. Issues related either to health, housing or anything that need to be discussed is taken up. Basically, a lot of mobilisation and education has to be undertaken on issues and on public policies. In Karnataka, policies were brought about by women's voices in 1981 which is evident from their Memorandum. In 1981, they were giving pension only to women who are physically handicapped. There were no benefits for widows but it was introduced by Women's Voice. They look at the policies all the time and have realised there is no policy for the urban poor in Karnataka. The City Corporation deals with health through the Corporation hospital outlets. There is no strong urban health systems. All this is looked at by the organisation which constantly demands for policy changes and policy interventions."

11. FIELD WORKER

She feels that health issues cannot be isolated from other survival issues. She says that the Andhra government sells subsidised rice at Rs.2 per kilogram, but the price of ragi is Rs. 8 per kilogram. In such a case, how does the government expect the poor to survive even if they are given the best of health facilities?

When she talks about the survival process with the doctors, they do not show any interest as it is not their responsibility. So she wants to know where to go from here. It is a problem that pursues female society.

"In Andhra Pradesh the Public Distribution System (PDS) is looking at Rs.2/kg rice which is not beneficial at all to the poor women in poor areas. The PDS never considered the food, culture and nutrition nor has thought about what the drought and backward areas get. They need jowar rather than white rice, jaggery rather than sugar and little oil rather than kerosene and a few other things which are very costly. Most of the people in tribal areas do not use kerosene. So this type of Public Distribution System is affecting the nutrition of the poor people.

White rice has no nutritive value. Dals are not being distributed through this system. Red chilly powder with white rice does not provide any nutrition. Jowar with tamarind is more nutritious than white rice and mirchi powder. Another factor is the link between rice millers in developed districts and the government. They connive and create a market for the paddy growers in developed districts. That is the reason for the introduction of the Rs.2 rice scheme and the habit of eating white rice was cultivated in 1983. Now after ten years, people find it difficult

to go back to eating other foods. The price of ordinary rice today is more than Rs.12/kg which is not affordable by common people. These are the repercussions that need to be looked into regarding the PDS. The seema people eat ragi as their staple food and the Telengana people eat jowar rotis as their staple food. The poor in the developed districts of Coastal Andhra Pradesh eat rice and many in the undeveloped parts of Srikakulam district eat broken rice."

KEY AREAS OF CONCERN:

* HIV/AIDS and Human Rights Violations.
* Poor health infrastructure both in urban and rural areas.
* Growing destitution for women in prostitution.
* Availability of safe abortion.
* Availability of legal redress for violations against women.
* The lack of accountability in the medical profession.
* Responsible trade unionism.
* Public Interest Litigation.
* Social security.
* Poor women, health and survival issues.

CHAPTER 9 [c]

RECOMMENDATIONS

To All Sectors:

* Strengthen commitments to women's rights.

* Guarantee women's reproductive rights as human rights.

* Recognize women's right to mobility and a life free of violence.

To The Government:

* Acknowledge and enforce women's human rights to housing, water, sanitation facilities, education and employment.

* Provide women with social security and savings and credit facilities.

* Undertake legislative and policy reforms that recognize, enhance and implement women's reproductive rights.

* Facilitate and enforce women's right of access to holistic health care, including reproductive health, and take all necessary steps to reduce maternal mortality.

* Guarantee that government family planning services provide women with comprehensive information on all aspects of health care, including contraception, ultrasonography and medical termination of pregnancy, and enable women to make informed choices.

* Enhance women's access to the legal system by creating legal aid organizations that meet the needs of the indigent.

To Private Providers of Reproductive Health Services:

* Transform current family planning services into a broad range of quality reproductive health services that are accessible to all and that meet the needs of women.

* Increase outreach to male clients so as to enhance male responsibility for matters relating to family and reproductive health.

* Improve the quality of all current services.

* Guarantee women's access to comprehensive information on all aspects of health care, including contraceptives, ultrasonography, medical termination of pregnancy, and enable them to make informed choices.

Women's NGOs:

* Lobby and advocate for changes that support women's control over material, human and intellectual resources.

* Sustain critical dialogue with the government on population policies and responsible public health care.

* Make professionals, trade unions, voluntary organizations and medical institutions accountable to the position and condition of women.

* Regulate and monitor the safety, efficacy and acceptability of reproductive and contraceptive technologies.

APPENDIX

APPENDIX

a) Hivos POPULATION SURVEY PAPER

HIVOS and population - a survey

1. Introduction

The threatening imbalance between the size of the world population and available resources is affecting the possibilities for development and change. The call for a global policy aimed at curbing population growth is becoming ever louder and has been heard for many years in development cooperation circles. Every year the Dutch government devotes considerable sums to birth control programmes. The discussion about whether a population policy needs to be developed and the consequences thereof for development programmes has of course implications for HIVOS's activities.

So HIVOS has cause to reflect on the population issue. Various considerations come into the picture here.

First of all, there is concern about population growth in both absolute and relative terms. According to forecasts, world population growth will outstrip the long-term availability of resources, even if a fairer distribution of resources and income is achieved within the North and the South, and between the North and the South. In various parts of the North and the South, population pressure is having a severe impact on the environment. That applies to the western countries, which are making the heaviest demands on available resources and contributing in large measure to global environmental degradation, but is true as well for Third World countries. Local population pressure in the South can have far-reaching effects on the environment, employment, distribution of land and water, social services, etc.

Second, HIVOS is concerned about the one-sided focus on population growth in the South. As Els Postel has fittingly observed, the daily traffic jams on Holland's roads do not immediately turn one's thoughts to contraceptives in the way pictures of starving African people often do. Yet it would be quire logical to argue that the earth can support only a very limited number of people who travel by motor car over a vast network of paved roads, as compared to people who normally travel on foot.

In the third place, there is concern about the way some countries act in either curbing or stimulating population growth. This is often at variance with the fundamental right of people to determine themselves how many children they'll have. There is a strong tendency to translate population policy exclusively into family-planning targeted mainly at-married-women. This focus on contraception means that other factors of influence to a birth rate decline are left out, like better education and employment for women. The lob-sided attention on contraceptives for female users, denies men's role and responsibility in the reproduction process. Furthermore, these contraceptives do not guarantee any protection against AIDS, a subject highly neglected in the discussions on population policy. Women run a high risk of HIV - infection because of their weak bargaining power in sexual matters. Moreover, the chances of virus-transmission to unborn children by pregnant HIV-infected women are high. In African countries AIDS already has led to the elimination of large proportions of the productive and reproductive active people.

2. HIVOS and population.

In HIVOS's view, there are clear interactions between population growth, local population pressure and development. The population issue is a global problem that cannot be reduced to a simple question of distribution of resources between North and South, or translated one-sidedly into family-planning. HIVOS view on population matters is determined by its integral development approach, in which an active global environmental policy, pursuit of fair trade relations, poverty alleviation and empowerment of poor people go hand in hand with strengthening the position and self-determination of women and changing the unequal power relations between men and women.

As a humanistic development organization, HIVOS wishes to contribute to the emancipation and autonomy of poor people. The right to regulate one's own fertility - without any pression either by government, partner or family - is part of this process. The underlying idea is that responsible and independent individulas are quite capable of determining themseleves how many children they want, on the basis of their economic situation, cultural values and wishes for the future. Yet this presupposes that:

* women and men have access to safe and reliable contraception, abortion and help with undesired infertility

* women can decide themseleves whether or not to bear children

* women have some prospect of a better life.

It is well enough known that in practice shortcomings in these areas exist. Furthermore, there are certain tensions between women's self-determination over their own bodies and lives, cultural and religious values and the unequal power relation between men and women. This is one of the reasons why HIVOS stresses the importance of gender-aware policy aimed at the empowerment and self-determination of women and emancipation of men.

We could stop here and leave it at this. However, the question is whether it's desirable - if not necessary - for a development organization as HIVOS to formulate a population policy in order to overcome the dilemma of short-term/long term solutions for population problems. If so, how do individual rights to self-determination relate to collective survival interest? Does HIVOS humanist vision leads to a different positionin the population dabate in comparison to religious development organizations? If so, what are the implications for HIVOS' policy?

Before dealing these questions, it is necessary to pay attention to HIVOS' partner organizations' view on population issues.

2.1 Population and reproductive rights in HIVOS's programme.

For many intermediary NGOs supported by HIVOS, population policy and local population pressure are sensitive issues Discussions related to these matters are immediately associated

with Northern hypocrisy. While the North refuses to tackle its own pollution and over-consumption or take serious steps to being about fair trading relations, it's pointing an accusing finger at population growth in the South. Besides, the history of family planning in developing countries (in many cases financed by western governments) is loaded and programmes involving social coercion or financial incentives are still being implemented. Because of the large-scale approach, many family-planning programmes are not tailored to the needs of the user. Nor do they link up with existing ideas and beliefs on reproduction and sexuality. Where male resistance to, say, the use of condoms or vasectomy, can always count on comprehension and caution, female aversion or fears regarding certain contraceptive methods is seldom dealt with.

Partner organizations argue that population growth does not cause poverty but rather that population growth is stimulated by poverty. Children are needed as help in the home and on the land, as a source of income (child labour) and as old age insurance. Infant mortality rate and the fact that in different societies a large number of children (preferably sons) gives women and men status, are also to be taken into account.

Furthermore, subjects related to sexuality and sexual options, gender, shared parenthood and birth control are often regarded as private family affairs and as such out of the scope of development programmes. One of the reasons is that local development organizations are mainly directed by men, who have difficulties themselves in discussing sexuality or recognizing the reproductive rights of women and the importance of responsible parenthood. Those subjects are often considered to be the exclusive domain of either specialized (medical) institutes or specific women's organizations, which furthermore have to be very sure of their ground to promote the self-determination of women (and men), rejecting the ideal images of the family and motherhood propagated by the church and the media. Women's organizations supported by HIVOS are stressing the importance of delinking population policy and family planning. They prefer to situate birth control within the broader framework of an integral approach of reproductive rights, embracing information, education, women's health care and the provision of safe and reliable contaceptives in accordance with the wishes of women and men.

Talks with the target group of rural development organizations with which HIVOS cooperates have shown time and again that there is a great need for information about sexuality and parenthood, for knowledge of the human body and for services in the area of contraception and women's health care. Although children are regarded as a gift of God in many societies, experience has shown that many women would consider it an even greater gift if conception could be deferred.

HIVOS therfore dares to question the prevailing view of many NGOs that poor people need to have many children for economic reasons. Quite apart from the fact that this presupposes some form of birth control, it is at variance with the wish expressed by millions of women to bear fewer children. Large families confront breadwinners and carers with enormous problems, and it is largely women who have to provide the solutions. Successive pregnancies limit women's room for personal development and leaves them physically exhausted. Furthemore, experience shows that women derive little joy from a pregnancy if they are already at a loss as to how to feed and care for the children and

relatives they're responsible for. And if they succeed in keeping their children alive, there is still the problem of the future. The realization that there is no money to give all their children a decent education and not enough land to be divided later is a heavy mental burden for parents. The argument that children can help to increase the family income is only partially valid. Although calculations in India have shown that children (can) contribute more to the family income than it costs to feed and clothe them, one may ask oneself whether parents really deliberately choose to supplement the family income in this way. We are left with the argument that children are needed as carers for their parents in their old age. Children do often fulfil this role in countries where there are no old-age pensions or other welfare services for the old. Here the dilemma arises that poor parents might be better off financially if they had only a few children but with an education and propects of reasonably paid work, whereas as regards physical care, they would derive more benefit from children who have no other option but to remain living at home or in the neighbourhood.

3. HIVOS and population policy

The concern about population growth in relation to available resources and the prolems indicated above in the area of reproductive rights cannot but have implications for HIVOS policy. This does not mean that HIVOS should develop a separate population policy, complete with target figures. But neither does HIVOS wish to ignore the population problem. Between the two extremes a whole range of possibilities are to be explored. Starting point is HIVOS' integral approach which embraces poverty alleviation. enviromental policy and emancipation.

An immediate clue for a more active line is the paradox of population policy, to which experts such as Els Postal have drawn attention. On the one hand, family-planning programmes put women under pressure to restrict the number of children they have, but on the other hand there arecountless women who would do this voluntarily if only they had access to the means. It is particularly in this area of tension between demand and supply that HIVOS likes to contribute.

The reasons to do so can be summarized as follows:

* In the groups supported (directly or indirectly) by HIVOS there is an expressed need to be able to control one's own fertility.

* At the same time, there is a great lack of information and services in the areas of sexual education, safe contraception, fertility problems and women's health care.

* The demand side is not homogeneous. Women and men have different needs with respect to information and means according to their age, background and sex. This should be kept in mind when providing these kind of services.

* The attitude of the Cathlic church and fundamentalist religious groups and their extensive interference with the legalization and realization of reproductive rights constitute a major obstacle for people's right to control their own fertility, which HIVOS regards as fundamental.

* Education and information concerning sexuality, reproductive and sexual options and opening up public debate on these issues are important weapons in the battle against AIDS.

* If women have more control over their own fertility, this has a positive effect on her possibilities for personal development. On the other hand, if women have a better access to education and better paid jobs, fertility rates will tend to decline.

* Also the number of maternal deaths and infant mortality will decrease, if women have acess to safe and reliable contraception.

* Reduction of (local) population pressure will in the long term help to slow down environmental degradation and improve the (local) food supply situation and employment.

What are the implications for HIVOS' activities and how can HIVOS respond to its concern regarding population issues and reproductive rights? In the next paragraph a few ideas are presented.

4. Proposals

4.1. Implementation of gender-conscious policy

There are close links between, on the one hand, the level of education/training, employment and adequate health care for women and, on the other hand, the number of children women have. If women and girls are better educated and are able to earn an income of their own, this has a positive effect on their "bargaining-power" vis-a-vis men.

The memo on HIVOS's policy on women and development indicates how HIVOS thinks it can contribute to a structural improvement in the position of women. One of the points of departure for this policy is the right of women to control their own lives and bodies. This right is not endorsed with the same enthusiasm by all partner organizations.

In the discussions with partner organizations engaged in a broad range of development activities, HIVOS should pay more attention to reproductive rights and physical autonomy of women and urge that these matters, along with sexuality and shared parenthood, be given greater prominence in these organizations' programmes and no longer be regarded as the exclusive domain of women's organizations. Partner organizations must become more aware of the fact that the democratization of society does not stop at the threshold of people's homes. Changes in relations between men and women and sexual behaviour are not after all a task solely for women. Men will have to become more involved in information and serivces in the area of sexuality and family planning and realize that their role in reproduction is not limited to procreation.

The raising of subjects such as reproductive rights in conjunction with population issues is certainly not an easy task, and HIVOS must prevent this from being seen as the latest donor fashion, fixed on the agenda next to environment and AIDS. Furthemore, the subject is not equally relevant to all the programmes supported by HIVOS.

4.2 Strategic choices

Support of NGOs that operate in the tension-area between supply and demand for save and reliable contraceptives, information on sexual matters and reproductive rights, women's health etc. is one to respond to our concern regarding reproductive rights and population matters. We have in mind here NGOs that provide services as mentioned above as well tackle ideological and legal issues, undertake steps to overturn the ideal images of the family motherhood propagated by the church and the media, and make a stand in favour of the legalization of abortion, etc. Research on ideas concerning reproduction, sexuality and people's aversion to, or problems with, certain methods of contraception should form part of such programmes. It would be desirable to make use of the WGNRR network in searching for NGOs that are operating as above indicated.

However, most of the NGOs engaged in programmes on reproductive rights are (urban) women's oranizations, with a limited access to rural areas. They could be encouraged, perhaps, to spread their wings and cover rural areas and/or advise partner organizations already active there. At the same time HIVOS should encorage partner organizations to a closer cooperation with them.

3. Inventory

HIVOS already supports some NGOs concerned with reproductive rights in Asia, Latin America and Africa. In order to get a picture of what is being achieved in education, services and campaigning in this area-as far as HIVOS-partners are concerned-an inventory will be made in 1993 with the aim of collecting and exchanging successful experiences and detecting bottlenecks.

4. Innovation

On the basis of this inventory, which will be completed in the second half of 1993, recommendations will be formulated for research, for promoting the exchange of information, for supporting innovative projects in the area of reproductive rights and for overturning traditional images on motherhood and the family. Three countries will be selected from three continents. It's obvious that (modest) funds will be made available for these activities and the support of innovative projects.

23/12/92/CS

APPENDIX

b) THE CAIRO CONFERENCE

THE CAIRO CONFERENCE

A programme of Action for Reproductive Rights?

The 1994 International Conference on Population and Development (the "ICPD") was a watershed event. Representatives from over 180 nations met in Cairo and agreed to the centrality of women in all discussions of populations and development. Although the conference was characterized by opposition from certain religious coalitions and a continued concern with high population growth rates, it is the first United Nations population conference that endorsed "reproductive rights". The success of the ICPD Programme of Action, measured in terms of improving women's lives, will depend upon the actions taken by governments and non - government organizations ("NGOs") in the years to come. NGOs must devise strategies to hold governments accountable and to ensure that the promises of reproductive rights and empowerment do not ring hollow. An understanding of those portions of the ICPD Programme of Action that represent important advances for women will facilitate the development of such strategies.

International Human Rights

Population policies seek to influence the most intimate and profound decisions of individual's life. All United Nations population conference documents, therefore, have called for respecting human rights. The ICPD Programme of Action, however, is notable for its endorsement of a range of human rights. The document not only recommends that national population policies respect international human rights norms, it also endorses a host of rights - such as the right to development, the right to health, the right to education, and the right to decide the number and spacing of children - that are applicable to a broad range of development policies. The opening paragraph of the introductory chapter, entitled "Principles", reflects the increasing importance of international human rights and the political compromises crafted to maintain consensus.

> The implementation of the recommendations contained in the ICPD Programme of Action is the sovereign right of each country, consistent with national laws and development priorities, with full respect for the various religious and ethical values and cultural back grounds of its people, and in conformity with universally recognized international human rights.

Because human rights principles elevate women's need for dignity, and respect to the level of a right, most women's health advocates have enthusiastically supported the call to integrate international human rights principles into the ICPD document. Hence the call for the governments to exercise their sovereignty consistent with international human rights. Yet certain countries opposed to the universal application of international human rights have argued for sovereign right to enact laws, regardless of their human rights implications, so long as such laws respect religious and other values. For example, Iran registered its reservation to all language in the chapter entitled " Principles " which dealt with sexual relationships outside of marriage and other acts not consistent with Islam. In an attempt to balance these perspectives, the ICPD Programme of Action declares that its recommendations must be implemented consistent with

national law and international human rights and with respect for the diversity of religious and ethical values. But what occurs when a government seeks to implement the ICPD Programme of Action recommendations by enacting policies that are consistent with national laws but inconsistent with international human rights law ? The ICPD document does not wrestle with this problem.

Empowerment of Women

The ICPD Programme of Action has been heralded for articulating and reflecting a dramatic shift in global population policy through its recognition of the pivotal role of women. The document approaches women's empowerment holistically by acknowledging the multi-faceted nature - economic, cultural, social and legal - of the policies that must be employed to improve women's lives. The key paragraph of the ICPD Programme of Action regarding women's empowerment is as follows :

> 4.1 The empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself. In addition, it is essential for the achievement of suitable development. The full participation and partnership of both women and men is required in productive and reproductive life, including shared responsibilities for the care and nurturing of children and the maintenance of the household. In all parts of the world, women are facing threats to their lives, health and well - being as a result of being overburdened with work and of their lack of power and influence. In most regions of the world, women receive less formal education than men, and at the same time women's own knowledge, abilities and coping mechanisms often go unrecognized. The power relations that impede women's attainment of healthy and fulfilling lives operate at many levels of society, from the most personal to the highly public. Achieving change requires policy and programme actions that will improve women's access to secure livelihoods and economic resources, alleviate their extreme responsibilities with regard to housework, remove legal impediments to their participations in public life, and raise social awareness through effective programmes of education and mass communication.

Based upon these principles, the ICPD Programme of Action strongly recommends government actions that support women's empowerment. The vast majority of ICPD participants endorsed this perspective. However, a minority of Islamic nations indicated a degree of discomfort with such strong language on women's rights. For instance, Libya expressed a reservation to all sections of the chapter entitled " Gender Equality, Equity and Empowerment of Women" to the extent that they contradicted Islamic law, particularly as it relates to inheritance rights and sexual behaviour. Nonetheless, the ICPD document does not bow to regressive minority views on women's equality and empowerment.

Reproductive Health

A necessary prerequisite to the empowerment of women in the provision of health services and, particularly, reproductive health care. To date, many population programs have focused on the provision of a narrow range of contraceptive services in the context of family planning clinics. Such programs thus respond only to one of women's health needs. The ICPD Programme of Action acknowledge the need for a broader approach to health as it relates to population and

population policies. The document also endorses a modified version of the World Health Organization (the "WHO:") definition of the term " reproductive health."

> 7.2 Reproductive health is a state of complete physical, mental and social well- being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

The ICPD programme of Action's endorsement of a reproductive health approach is a major success for women's health advocates. Paragraph 7.6 of the document urges governments to provide women and men with a host of services such as pre- and post- natal care, safe delivery, and treatment of infertility, reproductive tract infections, and sexually transmitted diseases. As to the abortion services, paragraph 7.6 suggests that services be limited in the manner specified in paragraph 8.25, the key abortion paragraph that is discussed below. This shift toward a reproductive health perspective was achieved despite opposition from a handful of participants. The Holy See expressed reservations to the entire chapter entitled " Reproductive Rights and Reproductive Health". Malta registered reservations to this chapter's title. Several Islamic nations - Afghanistan, Brunei, Djibouti, Kuwait, Libya, and Yemen - also reserved on terminology that they regarded as being in contradiction to Islamic law. These conservative forces served to dilute references to sexual health and sexual rights throughout the entire ICPD Programme of Action. They also forced all references to " fertility regulation" - a phrase defined by the WHO to include certain abortion - related services - to be replaced by " regulation of fertility, " a phrase that has no pre- determined definition. Moreover, in paragraph 7.2, the scope of the term "regulation of fertility" is further circumscribed. Women and men are to regulate their fertility only by methods that are " not against the law". Nonetheless, the ICPD Programme of Action remains unequivocal in its support for a broad-based reproductive health approach.

Reproductive Rights

One of the singular accomplishments of the ICPD Programme of Action is its support for "reproductive rights". The ICPD Programme of Action is also the first United Nations population conference document that begins to delineate the core elements of this right :

7.3 Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United nations consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community - supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.

Given the importance of reproductive rights to a woman - centered approach to population issues, it is not surprising that this section of the ICPD document served as a lightening rod for opponents of change. Conservative religious forces led by the Holy See questioned the validity of the very concept of "reproductive rights." Not only did they regard this right as one not previously recognized by the United Nations, but they also argued that the phrase includes a right to abortion on demand. Nicaragua and the Dominican Republic specifically registered a reservation to the phrase "reproductive rights" on the basis that they regarded life as beginning at conception. Several governments also expressed concerns about who would have the "right" to make reproductive decisions. Governments intensely debated whether "couples and individuals" or just "couples" had the right to decide the number and spacing of children. Nations such as Egypt, El Salvador, and the Dominican republic supported conferring reproductive choice exclusively upon couples in a marital context. Once again, in an attempt to balance divergent views, the ICPD Programme of Action incorporates compromise language. It recognizes that "couples and individuals" should make reproductive decisions, but such decisions "should take into account ... [people's] responsibilities towards the community". In fact, the concept of responsible decision - making is mentioned no less than four times in this one paragraph. These references reflect a covert attempt to set parameters on reproductive choice. Although most people regard reproductive decisions as profoundly personal, the ICPD document suggests that people consider the social and economic consequences to " the community" of their decision to bear children. Despite ideological attacks, however, the ICPD Programme of Action endorses the principle of reproductive rights and the right of " couples and individuals" to determine the number and spacing of their children.

Family Planning

Given the many controversies relating to women's empowerment and reproductive rights, family planning was relatively uncontroversial at the ICPD. Although the Holy See had sought to jeopardize the concept of family planning by claiming that such services include abortions, it failed to mobilize support for its position. The ICPD Programme of Action thus states :

7.12 The aim of family - planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to ensure informed choice and make available a full range of safe and effective methods. The success of population education and family - planning programmes in a variety of settings demonstrates that informed individuals everywhere can and will act responsibly in the light of their own needs and those of their families and communities. The principle of informed free choice is essential to the long term success of family - planning programmes. Any form of coercion has no part to play. In every society there are many social and economic incentives and disincentives, in order to lower or raise fertility. Most such schemes have had only marginal impact on fertility and in some cases have been counterproductive. Governmental goals for family planning should be defined in terms of unmet needs for information and services. Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family - planning providers in the form of targets or quotas for the recruitment of clients.

The ICPD Programme of Action recognizes the centrality of informed choice to family planning programs. Coercion and abuse is rejected, as are incentives that seek to influence family size. The document's position on demographic targets, however, is unclear. On the one hand, the ICPD Programme of Action states that quantitative measures are " legitimately the subject of government development strategies". On the other hand, it recognizes that quantitative goals " should not be imposed upon family planning providers in the form of targets or quotas for the recruitment of clients". Does this mean that attempt to achieve broad fertility targets are acting in accordance with the ICPD Programme of Action? Can nations impose targets or quotas relating to the retention or treatment - as opposed to the " recruitment." - of clients? The ICPD document does not explicitly answer these important questions.

Safe Motherhood

During the preparatory meetings of the ICPD, Safe Motherhood programs were attacked by the Holy See and its allies on the ground that such programs were a subterfuge for abortion rights. This assault failed. The ICPD programme of Action states :

8.19 Maternal deaths have very serious consequences within the family, given the crucial role of the mother for her children's health and welfare. The death of the mother increases the risk to the survival of her young children, especially if the family is not able to provide a substitute for the maternal role. Greater attention to the reproductive health needs of female adolescents and young women could prevent the major share of maternal morbidity and mortality through prevention of unwanted pregnancies and any subsequent poorly managed abortion. Safe motherhood has been accepted in many countries as a strategy to reduce maternal morbidity and mortality.

The ICPD document thus recognizes the toll that unplanned motherhood may have on women's lives. However, because of the politicization of all issues perceived as abortion - related, the document falls short of strongly endorsing the need for safe motherhood policies. The ICPD Programme of Action merely states that safe motherhood " has been accepted by many countries" as one strategy by which to combat maternal morbidity. It does not recommend that governments support or expand these programs.

Abortion

Abortion was the most contentious issue at the ICPD. Perhaps unfortunately, the conflict over abortion thus received the greatest media coverage. The carefully crafted paragraph in the ICPD Programme of Action regarding abortion states :

> 8.25 In no case should abortion be promoted as a method of family planning. All governments and relevant inter-governmental and non - governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion***/ as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances in which abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post - abortion counselling, education and family planning services should be offered promptly which will also help to avoid repeat abortions.
>
> ***/ Unsafe abortion is defined as a procedure for terminating either by persons lacking necessary skills or in an environment lacking the minimal medical standards or both.
> (WHO/MSM/92.5).

This paragraph raises several important issues, including the use of the terms " unsafe abortion" and abortions that are " not against the law". Anti - choice forces, represented by the Holy See, Malta, Equador, and Argentina, argued that all abortions were unsafe for the fetus. The phrase " unsafe abortion", they argued, was thus redundant. The majority view is that there are indeed abortions that are safe for a woman seeking to end her unwanted or health - threatening pregnancy. The WHO definition of " unsafe abortion" was incorporated into the documents to clarify this issue. The paragraph also strongly endorses the sovereignty of the national legislative process in abortion - related matters. This endorsement appears to reject the role of national courts and appropriate human rights forums in dealing with abortion laws. It is also noteworthy that paragraph 8.25 does not refer to " legal abortions". it refers to abortions that are " not against the law". The two or three nations in the world with the most stringent abortion laws declared that they could not be asked to recommend legalizing abortion. Malta expressed a reservation to the phrase "abortion is not against the law" in paragraph 8.25. A positive aspect of the ICPD document is its acceptance of the importance of post - abortion counselling and care. Nations such as Bangladesh, Cyprus, Canada, Zambia and Zimbabwe were strong supporters of this principle. Thus, although the ICPD Programme of Action does not contain abortion rights language, it does recognize unsafe abortions as a public health crisis and does call for greater safety and compassion for women obtaining abortions.

Conclusion

It remains to be seen whether the ICPD Programme of Action will enhance reproductive health and rights. Because the document continues to express a concern with high global population growth rates, it can be regarded as espousing a utilitarian perspective - women should be empowered and educated because doing so will reduce fertility rates. The goal of population and development policies should be to promote egalitarian policies that enhance the quality of life for all, particularly, the reproductive health, socio - economic status, and equality of women. Moreover, although the ICPD Programme of Action articulates a paradigm shift toward a broader reproductive health approach, the financial commitments to making these services available do not even come close to matching those for family planning programs. The total cost of implementing the programs suggested by the ICPD document is estimated to be $ 21.7 billion by the year 2015. Of this amount, $13.8 billion is committed to family planning programs, $ 6.1 billion to reproductive health, and $1.5 billion to HIV / AIDS prevention. Nonetheless, the ICPD document is an important beginning. The promises contained within the ICPD Programme of Action, if implemented, would indeed transform women's lives and set the stage for true reproductive dignity and freedom.

Please note : This publication contains quotations from the unedited version of the Programme of Action, dated September 19, 1994, which was distributed immediately after the ICPD.

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APPENDIX

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WORKSHOP ON "WOMEN'S HEALTH & RIGHTS: RETHINKING POPULATION"

JUNE 15 - 17, 1995

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APPENDIX

e) VARIOUS ACTS

THE CHILD MARRIAGE RESTRAINT ACT, 1929[1]

[1*st October*, 1929]

An Act to restrain the solemnisation of child marriages

Whereas it is expedient to restrain the solemnisation of child marriages ; it is hereby enacted as follows :

Comments

Preamble—Use of..— It is true that the preamble and the aims and objects cannot be used for interpreting the statute. The preamble as well as the aims and objects of the Act can be used for limited purpose for ascertaining the conditions prevailing at the time of legislation and for finding out the purpose of the enactment by furnishing valuable historical material.[2]

Objects and reasons of the Act.— The objects and reasons of the Act are to be taken into consideration in interpreting the provisions of the statute and not the debates in Parliament on the Bill.[3]

Intention of Legislature.— In *Prithvi Pal Singh Bedi* v. *Union of India*,[4] it was held that literal meaning of the statute must be adhered to when there is no absurdity in ascertaining the legislative intendment and for that purpose the broad feature of the Act can be looked into.[5]

Principle of "noscitur a sociis"—Application of.— Where two constructions are possible, that which would be more conducive to reason and justice is to be preferred by applying the principle of *noscitur a sociis*.[6]

Punctuation marks—Effects.— It is well known that punctuation marks by themselves do not control the meaning of a statute when its meaning is otherwise obvious.[7]

Words, clear, intelligible and unambiguous—Must be given effect to.— If the language of the statute is clear and intelligible and does not admit of two meanings, effect must be given to the words used and thus the intention of the Legislature must be carried out.[8]

Mandatory rule and directory rule—Difference.—The difference between a mandatory rule and a directory rule is that while the former must be strictly observed, in the case of the latter, substantial compliance may be sufficient to achieve the object regarding which the rule is enacted. Certain broad propositions which can be deduced from several decisions of courts regarding the rules of construction that should be followd in determining whether a provision of law is directory or mandatory may be summarised thus: The fact that the Statute uses the word "shall" while laying down a duty is not conclusive on the question whether it is a mandatory or a directory provision. In order to find out the true character of the legislation the Court has to ascertain the object which the provision of law in question is to subserve and its design and the context in which it is enacted. If the object of law is to

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1. Published in the **Gazette of India**, 1927 Pt. V, p. 28.
2. Nagpur Hotel Owners Association *v.* Corporation of the City of Nagpur, A.I.R. 1979 Bom. 190 at p. 196 ; Baboolal *v.* Director of Municipal Administration, A.I.R. 1974 Bom. 219 relied on.
3. Chem Taong Shang *v.* Commander S. D. Baijal, 1988 (1) Crimes 524 at p. 529 (S.C.) ; *see also* Kameshwar Singh Srivastava *v.* IVth Additional District Judge, Lucknow, A.I.R. 1987 S.C. 138 at p. 141.
4. A.I.R. 1982 S.C. 1413.
5. Jumman *v.* State of Uttar Pradesh, 1988 Cr. L.J. 199 at p. 203 (All) ; *see also* **Manoj K. Seth *v.* R.J. Fernandez, 1991 Cr.L.J. 3253 at p. 3256 (Ker) ; Mohan Kumar Singhania *v.* Union of India, A.I.R. 1992 S.C. 1 at p. 21.**
6. Sipra Dey, Smt. *v.* Ajit Kumar Dey, A.I.R. 1988 Cal. 28 at p. 33 ; *see also* **Uma Kant v. Dr. Bhikalal Jain, (1992) I.S.C.C. 105 at p. 113-114.**
7. Dadaji alias Dina *v.* Sukhdeobabu, A.I.R. 1988 S.C. 150 at p. 156.
8. Chandrabhan Chunnilal Gour *v.* Dr Sharwan Kumar Kunnolal Gour, A.I.R. 1980 Bom. 49 at p. 51 ; *see also* **Mohan Kumar Singhania v.Union of India, A.I.R. 1992 S.C. 1 at p. 21 ; Keshavji Ravji and Co. v. Commissioner of IT., A.I.R. 1991 S.C. 1806 at p. 1812.**

be defeated by non-compliance with it, it has to be regarded as mandatory. But where a provision of law relates to the performance of any public duty and the invalidation of any act done in disregard of that provision causes serious prejudice to those for whose benefit it is enacted and at the same time who have no control over the performance of the duty, such provision should be treated as a directory one. Where, however, a provision of law prescribes that a certain act has to be done in a particular manner by a person in order to acquire a right and it is coupled with another provision which confers an immunity on another when such act is not done in that manner, the former has to be regarded as a mandatory one. A procedural rule ordinarily should not be construed as mandatory if the defect in the act done in pursuance of it can be cured by permitting appropriate rectification to be carried out at a subsequent stage unless by according such permission to rectify the error later on, another rule would be contravened. Whenever a statute prescribes that a particular act is to be done in a particular manner and also lays down that a failure to comply with the said requirement leads to a specific consequence, it would be difficult to hold that the requirement is not mandatory and the specified consequence should not follow.[1]

Interpretation must further and not frustrate the object of a statute.—Interpretation of a statute, contextual or otherwise must further and not frustrate the object of the statute.[2]

1. Short title, extent and commencement.—(1) This Act may be called the Child Marriage Restraint Act, 1929.

(2) It extends to the whole of India [3][except the State of Jammu and Kashmir] and it applies as also to all citizens of India without and beyond India :

[4][Provided that nothing contained in this Act shall apply to the Renoncants of the Union territory of Pondicherry.]

(3) It shall come into force on the 1st day of April, 1930.

2. Definitions.— In this Act, unless there is anything repugnant in the subject or context,—

[5][*(a)* ''child'' means a person who, if a male, has not completed twenty-one years of age, and if a female, has not completed eighteen years of age ;]

(b) ''child marriage'' means a marriage to which either of the contracting parties is a child ;

(c) ''contracting party'' to a marriage means either of the parties whose marriage is or is about to be thereby solemnised ; and

(d) ''minor'' means a person of either sex who is under eighteen years of age.

3. Punishment for male adult below twenty-one years of age marrying a child.— Whoever, being a male above eighteen years of age and below twenty-one, contracts a child marriage shall be punishable with simple imprisonment which may extend to fifteen days, or with fine which may extend to one thousand rupees, or with both

Comment

Penal provisions—Interpretation.— The provision authorizing confiscation is a drastic one. In regard to such a provision it is well accepted that Court should place construction which is in favour of the subject. Where the conjunction used is ''or'' unless there are compelling reasons to read ''or'' as ''and'' it is well settled that any word should be given its natural meaning. If it was intended that both the conditions must be satisfied there was no difficulty for the Legislature to use the expression ''and'' instead of ''or''.[6]

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1. Sharif-ud-din *v.* Abdul Gani Lone, A.I.R. 1980 S.C. 303 at pp. 305-06 ; *see* also State of Jammu and Kashmir *v.* Abdul Gani A.I.R. 1979 J.& K. 17 at p. 20 (F.B.) ; Messrs. Choudhary *v.* Frick India Ltd., A.I.R. 1979 Delhi 97 at p. 99.
2. Muddada Chavanna *v.* Karnam Narayana, A.I.R. 1979 S.C. 1320 at p. 1323.
3. Subs. by Act 3 of 1951, Schedule.
4. Ins. by Act 26 of 1968, Schedule.
5. Subs. by Act 2 of 1978, Sec. 2 (w.e.f. 2nd October, 1978).
6. Somisetti Ramanath *v.* District Supply Officer, Chittoor, A.I.R. 1979 A.P.9 at p. 20 ; *see* also Kamla Kant Singh *v.* Chairman/Managing Director, Bennete Colman and Co. Ltd., 1988 (1) Crimes 106 at p. 109 (All) ; *see also* N.K. Jain *v.* C.K.Shah 1991 Cr.L.J. 1347 at p. 1359 (S.C.).

4. Punishment for male adult above twenty-one years of age marrying a child.— Whoever, being a male above twenty-one years of age, contracts a child marriage shall be punishable with simple imprisonment which may extend to three months and shall also be liable to fine.

Comment

Whoever—Meaning of.— According to the Shorter Oxford English Dictionary, Vol. 2, p. 2543, "whoever" means "any one who, any who". The meaning given in Webster Comprehensive Dictionary, International Ed., Vol. 2 at p. 1437 is "any one without exception any person who".[1]

5. Punishment for solemnising a child marriage.— Whoever performs, conducts or directs any child marriage shall be punishable with simple imprisonment which may extend to three months and also be liable to fine, unless he proves that he had reason to believe that the marriage was not a child marriage.

Comments

If marriage of Hindu male below eighteen years of age or female below fifteen years of age is invalid or illegal.— The marriage of Hindu male below eighteen years of age with a Hindu girl of fifteen years of age is not invalidated or rendered illegal by the force of the Child Marriage Restraint Act of 1929. It will remain a valid marriage binding under the Hindu Law if otherwise performed under any recognised form of Hindu Law. It would be seen that the Child Marriage Restraint Act only restrains a marriage of minors and that is objective, but does not prohibit marriage rendering it illegal or invalid. It punishes those persons who arrange that marriage and actively participate in celebrating it. The minor spouses who get married are not punished under the Act. Once it be held that the marriage itself is not illegal or invalid under the Child Marriage Restraint Act, 1929, then a debt incurred by the major members of the family for marrying a minor member of the family will not be for an illegal purpose as the marriage is legal and the debt is incurred for the marriage. If may be that the consequence under the law would be that the major members be punished for their act in making arrangements for celebration of the marriage.[2]

"May" and "shall" .— The word "may" implies what is optional, but it should in some context in which it appears, mean "must". There is an element of compulsion. It is power coupled with a duty. In Maxwell on *Interpretation of Statutes,* 11th Ed., p. 31, the principle is stated thus : "Statutes which authorise persons to do acts for the benefit of others, or, as is sometimes said, for the public good or the advancement of justice, have often given rise to controversy when conferring the authority in terms simply enabling and not mandatory. In enacting that they 'may' or 'shall' 'if they think fit', or 'shall have power' or that 'it shall be lawful' for them to do such acts, a statute appears to use the language of mere permision but it has been so often dicided as to have become an axiom that in such cases such expressions may have to say the least a compulsory force, and so would seem to be modified by judicial exposition." The word "may" even if it was *prima facie* enabling, the Legislature may use it in the sense of "must" or "shall".[3]

6. Punishment for parent or guardian concerned in a child marriage.— (1) Where a minor contracts a child marriage, any person having charge of the minor, whether as parent or guardian or in any other capacity, lawful or unlawful, who does any act to promote the marriage or permits it to be solemnised, or negligently fails to prevent it from being solemnised, shall be punishable with simple imprisonment which may extend to three months and shall also be liable to fine :

Provided that no woman shall be punishable with imprisonment.

(2) For the purposes of this section, it shall be presumed, unless and until the contrary is proved, that where a minor has contracted a child marriage, the person having charge of such minor has negligently failed to prevent the marriage from being solemnised.

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1. Rai Bahadur Seth Shreeram Durgaprasad, Messrs. *v.* Director of Enforcement, A.I.R. 1987 S.C. 1364 at p. 1369.
2. Parasram *v.* Smt. Naraini Devi, A.I.R. 19[illegible] All. 357 at p. 359.
3. Delhi Ad[illegible] *v.* I.K. Nangia, A.I.R. 1979 S.C. 1977 at p. 1980 ; Sohan Lal *v.* Hodal Singh, A.I.R. 1979 All. 230 at p. 232; see also Lakshamanasami Gounder v. C.I.T.,(1992) 1 S.C.C. 91 at p. 95.

STATE AMENDMENT

Gujarat.— After Sec. 6 of the principal Act the following section shall be inserted namely :

"7. *Offences to be cognizable.*— Notwithstanding anything contained in the Code of Criminal Procedure, 1898 (V of 1898), now new Code of 1973 (2 of 1974), an offence punishable under this Act shall be deemed to be a cognizable offence within the meaning of the Code." [1]

Comment

Family.— The word "family" has to be given not a restricted but a wider meaning so as to include not only the head of the family but all members or descendants from the common ancestors who are actually living with the same head. The term "family" must always be liberally and broadly construed so as to include near relations of the head of the family. [2]

[3][7. **Offences to be cognizable for certain purposes.**— The Code of Criminal Procedure, 1973 (2 of 1974), shall apply to offences under this Act as if they were cognizable offences—

(a) for the purpose of investigation of such offences ; and

(b) for the purpose of matters other than *(i)* matters referred to in Sec. 42 of that Code, and *(ii)* the arrest of a person without a warrant or without an order of a Magistrate.]

8. Jurisdiction under this Act.— Notwithstanding anything contained in Sec. 190 of the [4][Code of Criminal Procedure, 1973 (2 of 1974)], no Court other than that of a[4][Metropolitan Magistrate or a Judicial Magistrate of the first class] shall take cognizance of, or try, any offence under this Act.

Comment

Offences under the Act cannot be tried by any Court other than the Courts referred therein.— There is an express prohibition under Sec. 8 of the Child Marriage Restraint Act that offences under the Act cannot be tried by any Court other than the Courts referred to therein. Even any other Court cannot take cognizance of such offences. In view of this express prohibition in the special law which has an overriding effect, it is evident that even though the committing Magistrate has committed the accused to stand their trial, for offences under the Penal Code, which are triable by the Sessions Court, will not have jurisdiction to try these offences under the Act. The reason underlying it is that there is an express prohibition in special law which has got overriding effect over the provisions of general law.[5]

9. Mode of taking cognizance of offences.— No Court shall take cognizance of any offence under this Act after the expiry of one year from the date on which the offence is alleged to have been commited.

10. Preliminary inquiries into offences.— Any Court, on receipt of a complaint of an offence of which it is authorised to take cognizance, shall, unless it dismisses the complaint under Sec. 203 of the [6][Code of Criminal Procedure, 1973 (2 of 1974)], either itself make an inquiry under Sec. 202 of the Code or direct a Magistrate subordinate to it to make such inquiry.

Comment

Power vested in Magistrate to postpone issue of process.— Any Magistrate on receipt of a complaint of an offence of which he is authorised to take cognizance may do one of the two things : (1) He may for reasons to be recorded in writing, if he thinks fit, postpone the issue of process for compelling the attendance of the person complained against. The content of the power vested in the Magistrate to postpone the issue of process for compelling

1. Ins. by Gujarat Act 11 of 1964, Sec. 2.
2. Baldev Sahai Bangia *v.* R. C. Bhasin, A.I.R. 1982 S.C. 1091 at pp. 1093- 94 ; *see* also **Madhuben** Natwarlal, *v.* Prajapati Parshottam Tulsidas, A.I.R. 1991 Guj. 40 at pp. 41-42.
3. Ins. by Act 2 of 1978, Sec. 3 (w.e.f. 2nd October, 1978).
4. Subs. by Sec. 4, *ibid.*
5. State of Gujarat *v.* Fulsinh Bhimsinh, A.I.R. 1971 Guj. 1 at p. 6.
6. Subs. by Act 2 of 1978, Sec. 5 (w.e.f. 2nd October, 1978).

the attendance of the person complained against, would also cover the power of issuing process for compelling the attendance of the person complained against. (2) After doing one of these two things, the Magistrate may either enquire into the case himself or he can direct any Magistrate subordinate to him to make an enquiry only for the limited purpose of ascertaining the truth or falsehood of the complaint.[1]

STATE AMENDMENT

Gujarat.— Section 10 is deleted.[2]

11. Power to take security from complainant .— [*Repealed by the Child Marriage Restraint (Amendment) Act, 1949 (41 of 1949), Sec. 7*].

[3][**12. Power to issue injunction prohibiting marriage in contravention of this Act.**— (1) Notwithstanding anything to the contrary contained in this Act, the Court may, if satisfied, from information laid before it through a complaint or otherwise that a child marriage in contravention of this Act has been arranged or is about to be solemnised, issue an injunction against any of the persons mentioned in Secs. 3, 4, 5, and 6 of this Act prohibiting such marriage.

(2) No injunction under sub-section (1) shall be issued against any person unless the Court has previously given notice to such person, and has afforded him an opportunity to show cause against the issue of the injunction.

(3) The Court may either on its own motion or on the application of any person aggrieved, rescind or alter any order made under sub-section (1).

(4) Where such an application is received, the Court shall afford the applicant an early opportunity of appearing before it either in person or by pleader ; and if the Court rejects the application wholly or in part, it shall record in writing its reasons, for so doing.

(5) Whoever knowing that an injunction has been issued against him under sub-section (1) of this section disobeys such injunction shall be punished with imprisonment of either description for a term which may extend to three months, or with fine which may extend to one thousand rupees, or with both :

Provided that no woman shall be puninshable with imprisonment.]

STATE AMENDMENT

Gujarat.— After Sec. 12 of the principal Act the following sections shall be added, namely :

"13 *Child Marriage Prevention Officer.*— (1) The State Government may, by notification in the official Gazette, appoint for the whole State or for such part thereof as may be specified in that notification, an officer to be known as Child Marriage Prevention Officer.

(2) It shall be the duty of the Child Marriage Prevention Officer—

(i) to prevent marriages being performed in contravention of the provisions of this Act by taking such action under this Act as he deems fit :

(ii) to collect evidence for the effective prosecutions of persons contravening provisions of this Act ; and

(iii) to discharge such other functions as may be assigned to him by the State Government.

(3) The State Government may, by notification in the official Gazette, invest the Child Marriage Prevention Officer with such powers of a police officer as may be specified in the notification and the Child Marriage Prevention Officer shall exercise his powers subject to such limitation and conditions as may be specified in the notification.

(4) The State Government may associate with each Child Marriage Prevention Officer a non-offical advisory body consisting of not more than five social welfare workers, of whom at least two shall be women workers known in the area within the jurisdiction of the officer for the purposes of advising and assisting him in the performance of his functions under this Act.

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1. Jagadeesa Thevar *v.* Rajabakiya Thevar, 1971 Cr. L.J. 1350 at p. 1351 (Mad.)
2. Deleted by Gujarat Act 11 of 1964, Sec. 3.
3. Ins. by Act 19 of 1938, Sec. 6

(5) The terms and conditions of appointment of persons on the advisory body shall be such as may be presribed by rules.

13-A. *Officer appointed under the Act to be public servant.* — The Child Marriage Prevention Officer appointed under Sec. 13 shall be deemed to be a public servant within the meaning of Sec. 21 of the Indian Penal Code (XLV of 1860).[1]

13-B. *Protection of action taken in good faith.*— No suit, prosecution or other legal proceedings shall lie against the Child Marriage Prevention Officer appointed under this Act in respect of anything in good faith done or intended to be done in pursuance of this Act or of any rules or orders made thereunder.[2]

14. *Power to make rules.*— (1) The State Government may, by notification in the official Gazette, make rules, for the purposes of carrying out the provisions of this Act.

(2) In particular and without prejudice to the generality of the foregoing provision, such rules may provide for all matters expressly required or allowed by this Act to be prescribed by rules.

(3) The power to make rules conferred by this section is subject to the condition of the rules made after previous publication.

(4) All rules made under this section shall be laid for not less than thirty days before the State Legislature as soon as possible after they are made, and shall be subject to rescission by the State Legislature or to such modification as the State Legislature may make during the session in which they are so laid or the session immediately following.

(5) Any rescission or modification so made by the State Legislature shall be published in the official Gazette and thereupon shall take effect.''[1]

THE MEDICAL TERMINATION OF PREGNANCY ACT, 1971

(Act No. 34 of 1971)

[10*th August*,1971]

An Act to provide for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto

Be it enacted by Parliament in the Twenty-second Year of the Republic of India as follows :

1. Short title, extent and commencement.—(1) This Act may be called the Medical Termination of Pregnancy Act, 1971.

(2) It extends to the whole of India except the State of Jammu and Kashmir.

(3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

2. Definitions.—In this Act, unless the context otherwise requires,—

(a) "guardian" means a person having the care of the person of a minor or a lunatic;

(b) "lunatic" has the meaning assigned to it in Sec.3 of the Indian Lunacy Act, 1912 (4 of 1912)[1];

(c) "minor" means a person who, under the provisions of the Indian Majority Act, 1875 (9 of 1875), is to be deemed not to have attained his majority ;

(d) "registered medical practitioner" means a medical practioner who possesses any recognized medical qualification as defined in Cl.*(h)* of Sec. 2 of the Indian Medical Council Act, 1956 (102 of 1956), whose name has been entered in a State Medical Register and who has such experience or training in gynaécology and obstetrics as may be prescribed by rules made under this Act.

Comments

General principle of construction.—There is one principle on which there is complete unanimity of all the courts in the world and this is that where the words or the language used in a statute are clear and cloudless, plain, simple and explicit, unclouded and unobscured, intelligible and pointed so as to admit of no ambiguity, vagueness,uncertainty or equivocation, there is absolutely no room for deriving support from external aids. In such cases, the statute should be interpreted on the face of the language itself without adding, subtracting or omitting words therefrom. Where the language so as to add or supply omissions and thus play the role of a political reformer or of a wise counsel to the Legislature.[2]

Person.—The word "person" has been used to make it clear that in order to exercise the powers of Controller under the Act, the statutory functionary has to be duly appointed by the Government and that he is *persona designata* or designated person.[3]

3. When pregnancies may be terminated by registered medical practitioners.—(1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner,—

(a) where the length of the pregnancy does not exceed twelve weeks if such medical practitioner is, or

(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are,

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1. Repealed by the Mental Health Act, 1987.
2. S.P. Gupta v. President of India, A.I.R. 1982 S. C. 149 at pp. 304,314.
3. V.K. Joseph v. State of Tamil Nadu, Madras, A.I.R. 1985 Mad. 118 at p. 119.

of opinion, formed in good faith, that.–

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health ; or

(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Explanation 1.–Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation 2.–Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

(3) In determining whether the continuance of pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant women's actual or reasonable foreseeable environment.

(4)*(a)* No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.

(b) Save as otherwise provided in Cl.*(a)*, no pregnancy shall be terminated except with the consent of the pregnant woman.

Comments

More than one registered medical practitioner not needed for actual termination of pregnancy.–The number of registered medical practitioners has relevance only with regard to the formation of the opinion. Once the opinion has been formed by the required number of registered medical practitioners, the actual termination of the pregnancy may be done by one registered medical practitioner. It is not necessary that more than one registered medical practitioner should act together to terminate a pregnancy.

The word "shall"–Meaning of–It has been laid down consistently by the Supreme Court that the mere use of the word "shall" by itself in the statute does not make the provision mandatory, but it is the duty of the courts of justice to try to get at the real intention of the Legislature by carefully attending to the whole scope of the statute to be construed. In each case, one has to look to the subject-matter, consider the importance of the provisions and the relations of that provision with the general object intended to be secured by the Act and upon the review of the case in that aspect decide whether the enactment is mandatory or only directory.[1]

"May" and "shall".–Where the Legislature use two words "may" and "shall" in two different parts of the same provision *prima facie* it would appear that the Legislature manifested its intention to make one part directory and another mandatory. But that by itself is not decisive. The power of the Court still to ascertain the real intention of the Legislature by carefully examining the scope of the statute to find out whether the provision is directory or mandatory remains unimpaired even where both the words are used in the same provision.[2]

The word "may" must be construed to mean "shall" and it is mandatory.[3]

Saving provision–Effect of.–While giving effect to a saving provision, when it provides that something which is done or issued under the repealed provision must be treated as having been treated or issued under the newly enacted provision, an earlier order can be saved only if such a direction or order could be effectively and validly made under the new provisions of law, which had repealed the earlier provisions.[4]

4. Place where pregnancy may be terminated.–No termination of pregnancy shall be made in accordance with this Act at any place other than,–

(a) a hospital established or maintained by Government, or

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1. Mohammad Mahbood Khan v. State Transport Appellate Tribunal, Uttar Pradesh, 1982 A.L.J.300 at p.301; see also Ganesh Prasad Sah Kesari v Lakshmi Narayan Gupta, A.I.R. 1985 S.C. 964 at p. 968.
2. Ganesh Prasad Sah Kesari v. Lakshmi Narayan Gupta, A.I.R. 1985 S.C. 964 at p.967.
3. Keshav Chandra Joshi v. Union of India, A.I.R. 1991 S.C. 284 at p. 294.
4. S.Alphone v. Dist. Supply Officer, Nagercoil, A.I.R. 1986 Mad. 20 at p.23.

(b) a place for the time being approved for the purpose of this Act by Government.

Comment

Pregnancy to be terminated at a Government hospital or approved place.—This section, read with Sec.5, provides that a pregnancy which is terminated on one or more of the grounds specified in Sec. 3, should not be made at any place other than—

(a) a hospital established or maintained by Government, or

(b) a place for the time being approved for the purpose of the Act by Government.

5. Sections 3 and 4 when not to apply.—(1)The provisions of Sec.4 and so much of the provisions of sub-section (2) of Sec. 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by the registered medical practitioner in case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

(2) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), the termination of a pregnancy by a person who is not a registered medical practitioner shall be an offence punishable under that Code, and that Code shall, to this extent, stand modified.

Explanation.—For the purposes of this section, so much of the provisions of Cl.*(d)*of Sec.2 as relate to the possession, by a registered medical practitioner, of experience or training in gynaecology and obstetrics shall not apply.

Comments

Explanation.—It is now well settled that an explanation added to a statutory provision is not a substantive provision in any sense of the term but as the plain meaning of the word itself shows it is merely meant to explain or clarify certain ambiguities which may have crept in the statutory provision.[1]

Proviso.—A proviso is intended to limit the enacted provision so as to except something which would have otherwise been within it or in some measure to modify the enacting clause. Sometimes a proviso may be embedded in the main provision and becomes an integral part of it so as to amount to a substantive provision itself.[2]

6. Power to make rules.—(1) The Central Government may, by notification in the Official Gazette, make rules to carry out the provisions of this Act.

(2) In particular, and without prejudice to the generality of the foregoing power, such rules may provide for all or any of the following matters, namely :

(a) the experience or training, or both, which a registered medical practitioner shall have if he intends to terminate any pregnancy under this Act ; and

(b) such other matters as are required to be or may be, provided by rules made under this Act.

(3) Every rule made by the Central Government under this Act shall be laid, as soon as may be after it is made, before each House of Parliament while it is in session for a total period of thirty days which may be comprised in one session or in two successive sessions, and if, before the expiry of the session which it is so laid or the session immediately following, both Houses agree in making any modification in the rule or both Houses agree that the rule should not be made, the rule shall thereafter have effect only in such modified form or be of no effect, as the case may be ; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

Comment

By this section, a power has been conferred on the Central Government to make rules to carry out the provisions of the Act.

In relation to hospitals other than institutions established or maintained by the Central Government, matters in respect of which regulations can be made by the State

1. S.Sundaram v. V. R. Pattabiraman, A.I.R. 1985 S.C. 582 at p.593.
2. Ibid., at p.592.

Government under Sec.7 have been included in the rules.

7. Power to make regulations.—(1) The State Government may, by regulations,—

(a) require any such opinion as is referred to in sub- section (2) of Sec.3 to be certified by a registered medical practitioner or practitioners concerned in such form and at such time as be specified in such regulations, and the preservation or disposal of such certificates ;

(b) require any registered medical practitioner, who terminates a pregnancy to give intimation of such termination and such other information relating to the termination as may be specified in such regulations ;

(c) prohibit the disclosure, except to such persons and for such purposes as may be specified in such regulations, of intimations given or information furnished in pursuance of such regulations.

(2) The intimation given and the information furnished in pursuance of regulations made by virtue of Cl.*(b)* of sub-section (1) shall be given or furnished, as the case may be, to the Chief Medical Officer of the State.

(3) Any person who wilfully contravenes or wilfully fails to comply with the requirements of any regulation made under sub-section (1) shall be liable to be punished with fine which may extend to one thousand rupees.

Comments

Under this section, the State Government has been empowered to make regulations requiring opinion referred to in sub-section (2) of Sec.3 to be certified and the preservation or disposal of such certificate ; to require the registered medical practitioner to give intimation of pregnancies terminated by them to the Chief Medical Officer of the State.

The matters in relation to which such regulations may be made have been specified in the section itself. It will be seen that the power to make regulations has been conferred on the State Government only. The regulations made by the State Governments would apply to hospital established or maintained by it or to approved places in the State. But as regards the Central institutions and hospitals, etc., situated in a Cantonment, the State Government has no power to make such regulations. Consequently, rules have been framed by the Central Government with regard to the matters in relation to which regulations can be made by the State Government.

The Act empowers the Central Government to make regulations to provide for the maintenance of secrecy about the termination of pregnancies made under the Act. The matters in relation to which such regulations may be made have been specified in the section itself. In relation to medical institutions established or maintained by the Central Government, provisions regarding the maintenance of secrecy, etc., have been included in the rules made under Sec. 6. The said rules would apply only to hospitals established or maintained by Government or other places approved by the Government. The regulations made under this section by any State Government would apply to hospitals established or maintained by the Government and places approved by it.

8. Protection of action taken in good faith.—No suit or other legal proceedings shall lie against any registered medical practitioner for any damage caused or likely to be caused by anything which is in good faith done or intended to be done under this Act.

Comment

By sub-section(1) of Sec. 3, a registered medical practitioner, who terminates a pregnancy in accordance with the provisions of the Act, is protected from any prosecution for the termination of such pregnancy. By this section, he is protected from any civil action for compensation for any damage caused or likely to be caused by anything which is in good faith done or intended to be done under this Act. In order to be able to get this protection, the registered medical practitioner must establish that his action was done in good faith. "Act" may also include omissions. Hence, if any omission to terminate any pregnancy is made in good faith, an action for compensation for damages may not lie for such omission if such omission was done in good faith.

रजिस्ट्री सं० डी०एल०-33004/94

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भारत का राजपत्र
The Gazette of India

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इस भाग में भिन्न पृष्ठ संख्या दी जाती है जिससे कि यह अलग संकलन के रूप में रखा जा सके।
Separate paging is given to this Part in order that it may be filed as a separate compilation.

MINISTRY OF LAW, JUSTICE AND COMPANY AFFAIRS

(Legislative Department)

New Delhi, the 20th September, 1994/Bhadra 29, 1916 (Saka)

The following Act of Parliament received the assent of the President on the 20th September, 1994, and is hereby published for general information:—

THE PRE-NATAL DIAGNOSTIC TECHNIQUES (REGULATION AND PREVENTION OF MISUSE) ACT 1994

No. 57 OF 1994

[*20th September*, 1994.]

An Act to provide for the regulation of the use of pre-natal diagnostic techniques for the purpose of detecting genetic or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex linked disorders and for the prevention of the misuse of such techniques for the purpose of pre-natal sex determination leading to female foeticide, and for matters connected there with or incidental thereto.

BE it enacted by Parliament in the Forty-fifth Year of the Republic of India as follows:—

CHAPTER I

PRELIMINARY

Short title, extent and commencement.

1. (1) This Act may be called the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1944.

(2) It shall extend to the whole of India except the State of Jammu and Kashmir.

(3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

Definitions.

2. In this Act, unless the context otherwise requires,—

(a) "Appropriate Authority" means the Appropriate Authority appointed under section 17;

(b) "Board" means the Central Supervisory Board constituted under section 7;

(c) "Genetic Counselling Centre" means an institute, hospital, nursing home or any place, by whatever name called, which provides for genetic counselling to patients;

(d) "Genetic Clinic" means a clinic, institute, hospital, nursing home or any place, by whatever name called, which is used for conducting pre-natal diagnostic procedures;

(e) "Genetic Laboratory" means a laboratory and includes a place where facilities are provided for conducting analysis or tests of samples received from Genetic Clinic for pre-natal diagnostic test;

(f) "gynaecologist" means a person who possesses a post-graduate qualification in gynaecology and obstetrics;

(g) "medical geneticist" means a person who possesses a degree or diploma or certificate in medical genetics in the field of pre-natal diagnostic techniques or has experience of not less than two years in such field after obtaining—

(i) any one of the medical qualifications recognised under the Indian Medical Council Act, 1956; or 102 of 1956.

(ii) a post-graduate degree in biological sciences;

(h) "paediatrician" means a person who possesses a post-graduate qualification in paediatrics;

(i) "pre-natal diagnostic procedures" means all gynaecological or obstetrical or medical procedures such as ultrasonography foetoscopy, taking or removing samples of amniotic fluid, chorionic villi, blood or any tissue of a pregnant woman for being sent to a Genetic Laboratory or Genetic Clinic for conducting pre-natal diagnostic test;

(j) "pre-natal diagnostic techniques" includes all pre-natal diagnostic procedures and pre-natal diagnostic tests;

(k) "pre-natal diagnostic test" means ultrasonography or any test or analysis of amniotic fluid, chorionic villi, blood or any tissue of a pregnant woman conducted to detect genetic or metabolic disorders or chromosomal abnormalities or congential anomalies or naemoglobinopathies or sex-linked diseases;

(l) "prescribed" means prescribed by rules made under this Act;

(m) "registered medical practitioner" means a medical practitioner who possesses any recognised medical qualification as defined in clause

(h) of section 2 of the Indian Medical Council Act, 1956, and whose name has been entered in a State Medical Register; 102 of 1956.

(*n*) "regulations" means regulations framed by the Board under this Act.

CHAPTER II

REGULATION OF GENETIC COUNSELLING CENTRES GENETIC LABORATORIES AND GENETIC CLINICS

Regulation of Genetic Counselling Centres, Genetic Laboratories and Genetic Clinics.

3. On and from the commencement of this Act,—

(*1*) no Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic unless registered under this Act, shall conduct or associate with, or help in, conducting activities relating to pre-natal diagnostic techniques;

(*2*) no Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic shall employ or cause to be employed any person who does not possess the prescribed qualifications;

(*3*) no medical geneticist, gynaecologist paediatrician registered medical practitioner or any other person shall conduct or cause to be conducted or aid in conducting by himself or through any other person, any pre-natal diagnostic techniques at a place other than a place registered under this Act.

CHAPTER III

REGULATION OF PRE-NATAL DIAGNOSTIC TECHNIQUES

Regulation of pre-natal diagnostic techniques.

4. On and from the commencement of this Act,—

(*1*) no place including a registered Genetic Counselling Centre or Genetic Laboratory or Genetic Clinic shall be used or caused to be used by any person for conducting pre-natal diagnostic techniques except for the purposes specified in clause (*2*) and after satisfying any of the conditions specified in clause (*3*);

(*2*) no pre-natal diagnostic techniques shall be conducted except for the purposes of detection of any of the following abnormalities, namely:—

(*i*) chromosomal abnormalities;

(*ii*) genetic metabolic diseases;

(*iii*) haemoglobinopathies;

(*iv*) sex-linked genetic diseases;

(*v*) congenital anomalies;

(*vi*) any other abnormalities or diseases as may be specified by the Central Supervisory Board;

(*3*) no pre-natal diagnostic techniques shall be used or conducted unless the person qualified to do so is satisfied that any of the following conditions are fulfilled, namely:—

(*i*) age of the pregnant woman is above thirty-five years;

(*ii*) the pregant woman has undergone of two or more spontaneous abortions or foetal loss;

(*iii*) the pregnant woman had been exposed to potentially teratogenic agents such as drugs, radiation, infection or chemicals;

(*iv*) the pregnant woman has a family history of mental retardation or physical deformities such as spasticity or any other genetic disease;

(*v*) any other condition as may be specified by the Central Supervisory Board;

(4) no person, being a relative or the husband of the pregnant woman shall seek or encourage the conduct of any pre-natal diagnostic techniques on her except for the purpose specified in clause (2).

Written consent of pregnant woman and prohibition of communicating the sex of foetus.

5. (1) No person referred to in clause (2) of section 3 shall conduct the pre-natal diagnostic procedures unless—

(*a*) he has explained all known side and after effects of such procedures to the pregnant woman concerned;

(*b*) he has obtained in the prescribed form her written consent to undergo such procedures in the language which she understands; and

(c) a copy of her written consent obtained under clause (*b*) is given to the pregnant woman.

(2) No person conducting pre-natal diagnostic procedures shall communicate to the pregnant woman concerned or her relatives the sex of the foetus by words, signs or in any other manner.

Determination of sex prohibited.

6. On and from the commencement of this Act,—

(*a*) no Genetic Counselling Centre or Genetic Laboratory or Genetic Clinic shall conduct or cause to be conducted in its Centre, Laboratory or Clinic, pre-natal diagnostic techniques including ultrasonography, for the purpose of determining the sex of a foetus;

(*b*) no person shall conduct or cause to be conducted any pre-natal diagnostic techniques including ultrasonography for the purpose of determining the sex of a foetus.

CHAPTER IV

CENTRAL SUPERVISORY BOARD

Constitution of Central Supervisory Board.

7. (1) The Central Government shall constitute a Board to be known as the Central Supervisory Board to exercise the powers and perform the functions conferred on the Board under this Act.

(2) The Board shall consist of—

(*a*) the Minister in charge of the Ministry or Department of Family Welfare, who shall be the Chairman, *ex officio*;

(b) the Secretary to the Government of India in charge of the Department of Family Welfare, who shall be the Vice-Chairman, *ex-officio;*

(c) two members to be appointed by the Central Government to represent the Ministries of Central Government in charge of Woman and Child Development and of Law and Justice, *ex-officio;*

(*d*) the Director General of Health Services of the Central Government, *ex officio*;

(*e*) ten members to be appointed by the Central Government, two each from amongst—

(*i*) eminent medical geneticists;

(*ii*) eminent gynaecologists and obstetricians;

(*iii*) eminent paediatricians;

(*iv*) eminent social scientists; and

(*v*) representatives of women welfare organisations;

(*f*) three women Members of Parliament, of whom two shall be elected by the House of the People and one by the Council of States;

(*g*) four members to be appointed by the Central Government by rotation to represent the States and the Union territories, two in the alphabetical order and two in the reverse alphabetical order:

Provided that no appointment under this clause shall be made except on the recommendation of the State Government or, as the case may be, the Union territory;

(*h*) an officer, not below the rank of a Joint Secretary or equivalent of the Central Government, in charge of Family Welfare, who shall be the Member-Secretary, *ex officio.*

Term of office of members.

8. (*1*) The term of office of a member, other than an *ex officio* member, shall be,—

(*a*) in case of appointment under clause (*e*) or clause (*f*) of sub-section (*2*) of section 7, three years; and

(*b*) in case of appointment under clause (*g*) of the said sub-section, one year.

(*2*) If a casual vacancy occurs in the office of any other members, whether by reason of his death, resignation or inability to discharge his functions owing to illness or other incapacity, such vacancy shall be filled by the Central Government by making a fresh appointment and the member so appointed shall hold office for the remainder of the term of office of the person in whose place he is so appointed.

(*3*) The Vice-Chairman shall perform such functions as may be assigned to him by the Chairman from time to time.

(*4*) The procedure to be followed by the members in the discharge of their functions shall be such as may be prescribed.

Meetings of the Board

9. (*1*) The Board shall meet at such time and place, and shall observe such rules of procedure in regard to the transaction of business at its meetings (including the quorum at such meetings) as may be provided by regulations:

Provided that the Board shall meet at least once in six months.

(*2*) The Chairman and in his absence the Vice-Chairman shall preside at the meetings of the Board.

(*3*) If for any reason the Chairman or the Vice-Chairman is unable to attend any meeting of the Board, any other member chosen by the members present at the meeting shall preside at the meeting.

(*4*) All questions which come up before any meeting of the Board shall be decided by a majority of the votes of the members present and voting, and in the event of an equality of votes, the Chairman, or in his absence, the person presiding, shall have and exercise a second or casting vote.

(*5*) Members other than *ex officio* members shall receive such allowances, if any, from the Board as may be prescribed.

Vacancies, etc., not to invalidate proceedings of the Board

10. No act or proceeding of the Board shall be invalid merely by reason of—

(*a*) any vacancy in, or any defect in the constitution of, the Board; or

(*b*) any defect in the appointment of a person acting as a member of the Board; or

(*c*) any irregularity in the procedure of the Board not affecting the merits of the case.

Temporary association of persons with the Board for particular purposes.

11. (*1*) The Board may associate with itself, in such manner and for such purposes as may be determined by regulations, any person whose assistance or advice it may desire in carrying out any of the provisions of this Act.

(*2*) A person associated with it by the Board under sub-section (*1*) for any purpose shall have a right to take part in the discussions relevant to that purpose, but shall not have a right to vote at a meeting of the Board and shall not be a member for any other purpose.

Appointment of officers and other employees of the Board.

12. (*1*) For the purpose of enabling it efficiently to discharge its functions under this Act, the Board may, subject to such regulations as may be made in this bahalf, appoint (whether on deputation or otherwise) such number of officers and other employees as it may consider necessary:

Provided that the appointment of such category of officers, as may be specified in such regulations, shall be subject to the approval of the Central Government.

(*2*) Every officer or other employee appointed by the Board shall be subject to such conditions of service and shall be entitled to such remuneration as may be specified in the regulations.

13. All orders and decisions of the Board shall be authenticated by the signature of the Chairman or any other member authorised by the Board in this behalf, and all other instruments issued by the Board shall be authenticated by the signature of the Member-Secretary or any other officer of the Board authorised in like manner in this behalf. Authentication of orders and other instruments of the Board.

14. A person shall be disqualified for being appointed as a member if, he— Disqualifications for appointment as member.

(*a*) has been convicted and sentenced to imprisonment for an offence which, in the opinion of the Central Government, involves moral turpitude; or

(*b*) is an undischarged insolvent; or

(*c*) is of unsound mind and stands so declared by a competent court; or

(*d*) has been removed or dismissed from the service of the Government or a Corporation owned or controlled by the Government; or

(*e*) has, in the opinion of the Central Government, such financial or other interest in the Board as is likely to affect prejudicially the discharge by him of his functions as a member; or

(*f*) has, in the opinion of the Central Government, been associated with the use or promotion of pre-natal diagnostic technique for determination of sex.

15. Subject to the other terms and conditions of service as may be prescribed, any person ceasing to be a member shall be eligible for re-appointment as such member. Eligibility of member for re-appointment.

16. The Board shall have the following functions, namely:— Functions of the Board.

(*i*) to advise the Government on policy matters relating to use of pre-natal diagnostic techniques;

(*ii*) to review implementation of the Act and the rules made thereunder and recommend changes in the said Act and rules to the Central Government;

(*iii*) to create public awareness against the practice of pre-natal determination of sex and female foeticide;

(*iv*) to lay down code of conduct to be observed by persons working at Genetic Counselling Centres, Genetic Laboratories and Genetic Clinics;

(*v*) any other functions as may be specified under the Act.

CHAPTER V

APPROPRIATE AUTHORITY AND ADVISORY COMMITTEE

17. (*1*) The Central Government shall appoint, by notification in the Official Gazette, one or more Appropriate Authorities for each of the Union territories for the purposes of this Act. Appropriate Authority and Advisory Committee.

(2) The State Government shall appoint, by notification in the Official Gazette, one or more Appropriate Authorities for the whole or part of the State for the purposes of this Act having regard to the intensity of the problem of pre-natal sex determination leading to female foeticide.

(3) The officers appointed as Appropriate Authorities under sub-section (1) or sub-section (2) shall be,—

(a) when appointed for the whole of the State or the Union territory, of or above the rank of the Joint Director of Health and Family Welfare; and

(b) when appointed for any part of the State or the Union territory, of such other rank as the State Government or the Central Government, as the case may be, may deem fit.

(4) The Appropriate Authority shall have the following functions, namely:—

(a) to grant, suspend or cancel registration of a Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic;

(b) to enforce standards prescribed for the Genetic Counselling Centre, Genetic Laboratory and Genetic Clinic;

(c) to investigate complaints of breach of the provisions of this Act or the rules made thereunder and take immediate action; and

(d) to seek and consider the advice of the Advisory Committee, constituted under sub-section (5), on application for registration and on complaints for suspension or cancellation of registration.

(5) The Central Government or the State Government, as the case may be, shall constitute an Advisory Committee for each Appropriate Authority to aid and advise the Appropriate Authority in the discharge of its functions, and shall appoint one of the members of the Advisory Committee to be its Chairman.

(6) The Advisory Committee shall consist of—

(a) three medical experts from amongst gynaecologists, obstericians, paediatricians and medical geneticists;

(b) one legal expert;

(c) one officer to represent the department dealing with information and publicity of the State Government or the Union territory, as the case may be;

(d) three eminent social workers of whom not less than one shall be from amongst representatives of women's organisations.

(7) No person who, in the opinion of the Central Government or the State Government, as the case may be, has been associated with the use or promotion of pre-natal diagnostic technique for determination of sex shall be appointed as a member of the Advisory Committee.

(8) The Advisory Committee may meet as and when it thinks fit or on the request of the Appropriate Authority for consideration of any application for registration or any complaint for suspension or cancellation of registration and to give advice thereon:

Provided that the period intervening between any two meetings shall not exceed the prescribed period.

(9) The terms and conditions subject to which a person may be appointed to the Advisory Committee and the procedure to be followed by such Committee in the discharge of its functions shall be such as may be prescribed.

CHAPTER VI

REGISTRATION OF GENETIC COUNSELLING CENTRES, GENETIC LABORATORIES AND GENETIC CLINICS

Registration of Genetic Counselling Centres, Genetic Laboratories or Genetic Clinics.

18. (1) No person shall open any Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic after the commencement of this Act unless such Centre, Laboratory or Clinic is duly registered separately or jointly under this Act.

(2) Every application for registration under sub-section (1), shall be made to the Appropriate Authority in such form and in such manner and shall be accompanied by such fees as may be prescribed.

(3) Every Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic engaged, either partly or exclusively, in counselling or conducting pre-natal diagnostic techniques for any of the purposes mentioned in section 4, immediately before the commencement of this Act, shall apply for registration within sixty days from the date of such commencement.

(4) Subject to the provisions of section 6, every Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic engaged in counselling or conducting pre-natal diagnostic techniques shall cease to conduct any such counselling or technique on the expiry of six months from the date of commencement of this Act unless such Centre, Laboratory or Clinic has applied for registration and is so registered separately or jointly or till such application is disposed of, whichever is earlier.

(5) No Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic shall be registered under this Act unless the Appropriate Authority is satisfied that such Centre, Laboratory or Clinic is in a position to provide such facilities, maintain such equipment and standards as may be prescribed.

Certificate of registration.

19. (1) The Appropriate Authority shall, after holding an inquiry and after satisfying itself that the applicant has complied with all the requirements of this Act and the rules made thereunder and having regard to the advice of the Advisory Committee in this behalf, grant a certificate of registration in the prescribed form jointly or separately to the Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic, as the case may be.

(2) If, after the inquiry and after giving an opportunity of being heard to the applicant and having regard to the advice of the Advisory Committee, the Appropriate Authority is satisfied that the applicant has not complied with the requirements of this Act or the rules, it shall, for reasons to be recorded in writing, reject the application for registration.

(3) Every certificate of registration shall be renewed in such manner and after such period and on payment of such fees as may be prescribed.

(4) The certificate of registration shall be displayed by the registered Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic in a conspicuous place at its place of business.

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20. (1) The Appropriate Authority may *suo moto*, or on complaint, issue a notice to the Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic to show cause why its registration should not be suspended or cancelled for the reasons mentioned in the notice.

(2) If, after giving a reasonable opportunity of being heard to the Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic and having regard to the advice of the Advisory Committee, the Appropriate Authority is satisfied that there has been a breach of the provisions of this Act or the rules, it may, without prejudice to any criminal action that it may take against such Centre, Laboratory or Clinic, suspend its registration for such period as it may think fit or cancel its registration, as the case may be.

(3) Notwithstanding anything contained in sub-sections (1) and (2), if the Appropriate Authority is, of the opinion that it is necessary or expedient so to do in the public interest, it may, for reasons to be recorded in writing, suspend the registration of any Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic without issuing any such notice referred to in sub-section (1).

ppeal.

21. The Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic may, within thirty days from the date of receipt of the order of suspension or cancellation of registration passed by the Appropriate Authority under section 20, prefer an appeal against such order to—

(i) the Central Government, where the appeal is against the order of the Central Appropriate Authority; and

(ii) the State Government, where the appeal is against the order of the State Appropriate Authority,

in the prescribed manner.

CHAPTER VII

OFFENCES AND PENALTIES

Prohibition of advertisement relating to pre-natal determination of sex and punishment for contravention.

22. (1) No person, organisation, Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic shall issue or cause to be issued any advertisement in any manner regarding facilities of pre-natal determination of sex available at such Centre, Laboratory, Clinic or any other place.

(2) No person or organisation shall publish or distribute or cause to be published or distributed any advertisement in any manner regarding facilities of pre-natal determination of sex available at any Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic or any other place.

(3) Any person who contravenes the provisions of sub-section (1) or sub-section (2) shall be punishable with imprisonment for a term which may extend to three years and with fine which may extend to ten thousand rupees.

Explanation.—For the purposes of this section, "advertisement" includes any notice, circular, label wrapper or other document and also includes any visible representation made by means of any light, sound, smoke or gas.

Offences and penalties.

23. (1) Any medical geneticist, gynaecologist, registered medical practitioner or any person who owns a Genetic Counselling Centre, a Genetic Laboratory or a Genetic Clinic or is employed in such a Centre, Laboratory or Clinic and renders his professional or technical services to or at such a Centre, Laboratory or Clinic, whether on an honorary basis or otherwise, and who contravenes any of the provisions of this Act or rules made thereunder shall be punishable with imprisonment for a term which may extend to three years and with fine which may extend to ten thousand rupees and on any subsequent conviction, with imprisonment which may extend to five years and with fine which may extend to fifty thousand rupees.

(2) The name of the registered medical practitioner who has been convicted by the court under sub-section (1), shall be reported by the Appropriate Authority to the respective State Medical Council for taking necessary action including the removal of his name from the register of the Council for a period of two years for the first offence and permanently for the subsequent offence.

(3) Any person who seeks the aid of a Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic or of a medical geneticist, gynaecologist or registered medical practitioner for conducting pre-natal diagnostic techniques on any pregnant woman (including such woman unless she was compelled to undergo such diagnostic techniques) for purposes other than those specified in clause (2) of section 4, shall, be punishable with imprisonment for a term which may extend to three years and with fine which may extend to ten thousand rupees and on any subsequent conviction with imprisonment which may extend to five years and with fine which may extend to fifty thousand rupees.

Presumption in the case of conduct of pre-natal diagnostic techniques.

1 of 1872.

24. Notwithstanding anything in the Indian Evidence Act, 1872, the court shall presume unless the contrary is proved that the pregnant woman has been compelled by her husband or the relative to undergo pre-natal diagnotic technique and such person shall be liable for abetment of offence under sub-section (3) of section 23 and shall be punishable for the offence specified under that section.

Penalty for contravention of the provisions of the Act or rules for which no specific punishment is provided.

25. Whoever contravenes any of the provisions of this Act or any rules made thereunder, for which no penalty has been elsewhere provided in this Act, shall be punishable with imprisonment for a term which may extend to three months or with fine, which may extend to one thousand rupees or with both and in the case of continuing contravention with an additional fine which may extend to five hundred rupees for every day during which such contravention continues after conviction for the first such contravention.

Offences by companies.

26. (*1*) Where any offence, punishable under this Act has been committed by a company, every person who, at the time the offence was committed was in charge of, and was responsible to, the company for the conduct of the business of the company, as well as the company, shall be deemed to be guilty of the offence and shall be liable to be proceeded against and punished accordingly:

Provided that nothing contained in this sub-section shall render any such person liable to any punishment, if he proves that the offence was committed without his knowledge or that he had exercised all due diligence to prevent the commission of such offence.

(*2*) Notwithstanding anything contained in sub-section (*1*), where any offence punishable under this Act has been committed by a company and it is proved that the offence has been committed with the consent or connivance of, or is attributable to any neglect on the part of, any director, manager, secretary or other officer of the company, such director, manager, secretary or other officer shall also be deemed to be guilty of that offence and shall be liable to be proceeded against and punished accordingly.

Explanation.—For the purposes of this section,—

(*a*) "company" means any body corporate and includes a firm or other association of individuals, and

(*b*) "director", in relation to a firm, means a partner in the firm.

Offence to be cognizable, non-bailable and non-compoundable.

27. Every offence under this Act shall be cognizable, non-bailable and non-compoundable.

Cognizance of offences.

28. (*1*) No court shall take cognizance of an offence under this Act except on a complaint made by—

(*a*) the Appropriate Authority concerned, or any officer authorised in this behalf by the Central Government or State Government, as the case may be, or the Appropriate Authority; or

(*b*) a person who has given notice of not less than thirty days in the manner prescribed, to the Appropriate Authority, of the alleged offence and of his intention to make a complaint to the court.

Explanation.—For the purpose of this clause, "person" includes a social organisation.

(*2*) No court other than that of a Metropolitan Magistrate or a Judicial Magistrate of the first class shall try any offence punishable under this Act.

(*3*) Where a complaint has been made under clause (*b*) of sub-section (*1*), the court may, on demand by such person, direct the Appropriate Authority to make available copies of the relevant records in its possession to such person.

CHAPTER VIII

MISCELLANEOUS

Maiute-nance of records.

29. (*1*) All records, charts, forms, reports, consent letters and all other documents required to be maintained under this Act and the rules shall be preserved for a period of two years or for such period as may be prescribed:

Provided that, if any criminal or other proceedings are instituted against any Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic, the records and all other documents of such Centre, Laboratory or Clinic shall be preserved till the final disposal of such proceedings.

(*2*) All such records shall, at all reasonable times, be made available for inspection to the Appropriate Authority or to any other person authorised by the Appropriate Authority in this behalf.

Power to search and seize records, etc.

30. (*1*) If the Appropriate Authority has reason to believe that an offence under this Act has been or is being committed at any Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic, such Authority or any officer authorised thereof in this behalf may, subject to such rules as may be prescribed, enter and search at all reasonable times with such assistance, if any, as such authority or officer considers necessary, such Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic and examine any record, register, document, book, pamphlet, advertisement or any other material object found therein and seize the same if such Authority or office has reason to believe that it may furnish evidence of the commission of an office punishable under this Act.

2 of 1974.

(*2*) The provisions of the Code of Criminal Procedure, 1973 relating to searches and seizures shall, so far as may be, apply to every search or seizure made under this Act.

Protection of action taken in good faith.

31. No suit, prosecution or other legal proceeding shall lie against the Central or the State Government or the Appropriate Authority or any officer authorised by the Central or State Government or by the Authority for anything which is in good faith done or intended to be done in pursuance of the provisions of this Act.

Power to make rules.

32. (*1*) The Central Government may make rules for carrying out the provisions of this Act.

(*2*) In particular and without prejudice, to the generality of the foregoing power, such rules may provide for—

(*i*) the minimum qualifications for persons employed at a registered Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic under clause (*1*) of section 3;

(*ii*) the form in which consent of a pregnant woman has to be obtained under section 5;

(*iii*) the procedure to be followed by the members of the Central Supervisory Board in the discharge of their functions under sub-section (4) of section 8;

(*iv*) allowances for members other than *ex officio* members admissible under sub-section (5) of section 9;

(*v*) the period intervening between any two meetings of the Advisory Committee under the proviso to sub-section (8) of section 17;

(*vi*) the terms and conditions subject to which a person may be appointed to the Advisory Committee and the procedure to be followed by such Committee under sub-section (9) of section 17;

(*vii*) the form and manner in which an application shall be made for registration and the fee payable thereof under sub-section (2) of section 18;

(*viii*) the facilities to be provided, equipment and other standards to be maintained by the Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic under sub-section (5) of section 18;

(*ix*) the form in which a certificate of registration shall be issued under sub-section (1) of section 19;

(*x*) the manner in which and the period after which a certificate of registration shall be renewed and the fee payable for such renewal under sub-section (3) of section 19;

(*xi*) the manner in which an appeal may be preferred under section 21;

(*xii*) the period up to which records, charts, etc., shall be preserved under sub-section (1) of section 29;

(*xiii*) the manner in which the seizure of documents, records, objects, etc., shall be made and the manner in which seizure list shall be prepared and delivered to the person from whose custody such documents, records or objects were seized under sub-section (1) of section 30;

(*xiv*) any other matter that is required to be, or may be, prescribed.

Power to make regulations.

33. The Board may, with the previous sanction of the Central Government, by notification in the Official Gazette, make regulations not inconsistent with the provisions of this Act and the rules made thereunder to provide for—

(*a*) the time and place of the meetings of the Board and the procedure to be followed for the transaction of business at such meetings and the number of members which shall form the quorum under sub-section (1) of section 9;

(*b*) the manner in which a person may be temporarily associated with the Board under sub-section (1) of section 11;

(*c*) the method of appointment, the conditions of service and the scales of pay and allowances of the officer and other employees of the Board appointed under section 12;

(*d*) generally for the efficient conduct of the affairs of the Board.

Rules and regulations to be laid before Parliament.

34. Every rule and every regulation made under this Act shall be laid, as soon as may be after it is made, before each House of Parliament, while it is in session, for a total period of thirty days which may be comprised in one session or in two or more successive sessions, and if, before the expiry of the session immediately following the session or the successive sessions aforesaid, both Houses agree in making any modification in the rule or regulation or both Houses agree that the rule or regulation should not be made, the rule or regulation shall thereafter have effect only in such modified form or be of no effect, as the case may be; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule or regulation.

K. L. MOHANPURIA,
Secy. to the Govt. of India.

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